Early Intervention Manual

South Carolina Department of Disabilities and Special Needs

July 1, 2007

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Introduction

This Manual is comprised of Procedural Bulletins that cover all of the required components of the service delivery system for children served by the Department of Disabilities and Special Needs as well as those children who are eligible for Part C services under The Individuals with Disabilities Education Act (IDEA) through BabyNet. While the BabyNet Policy and Procedure manual is reflective of current regulations regarding services to infants and toddlers, it must be used in coordination with this manual for those children who are either seeking eligibility or are currently eligible for DDSN services. The Department of Disabilities and Special Needs provides services to children from birth to three years of age through a contract with The South Carolina Department of Health and Environmental Control. Through this contractual relationship, DDSN agrees to provide services to children birth to three in accordance with Part C requirements. IDEA sets forth requirements for states in such key areas as the specific types of early intervention services which must be made available, procedural safeguards that must be in place to protect the rights of children and their families, and the expectations regarding the evaluation of children, the development of intervention plans, the provision of services in natural environments, and the involvement of families. Children who are eligible for DDSN services at the age of three may continue to receive service coordination and family training until the age of five if indicated.

Each Procedural Bulletin is designed to cover a particular component of the system. Early intervention providers use many words and acronyms with which readers may not be familiar. A glossary of many of these terms can be found at the end of this Manual. As state and federal regulations change or new requirements are added, Procedural Bulletins will be updated or developed and disseminated for substitution or inclusion in this Manual by The Office of Children's Services. Procedural Bulletins are designed to delineate requirements and provide basic philosophical and background information to assist the reader in understanding the intent of the regulations and to guide implementation of established expectations. Readers may obtain technical assistance from the DDSN, Office of Children's Services.

The Department of Disabilities and Special Needs, Office of Children's Services, wishes to acknowledge the use of policy and procedure documents from North Carolina in the development of this manual.

Note:
The word parent is used throughout this manual to mean the legal and custodial guardian of the child. For most children, this individual is the child's biological parent however, because this may not always be the case, readers must evaluate each situation and abide by appropriate custody regulation and practices.

For the sake of simplicity, the word parent has been used in the singular form. If there is more than one parent, both should be involved to the maximum extent possible.

What is Early Intervention?

The purpose of Early Intervention is to accelerate or maximize the development of children who are at significant risk for problems, in thinking, communicating, relating to others, emotional functioning, and body functioning. Research over the past 50 years has shown that early intervention is an effective tool in increasing the developmental and educational gains for the child, improving the functioning of the family unit, and providing long term benefits to society.

The life of a child is full of opportunities for learning, but from decades of child development research, we know that learning is most rapid in the infant/ toddler/preschool years. Every day, children encounter dozens of situation-specific experiences that involve interaction with people and their physical environment. It is through these experiences that children learn. However, physical limitations, visual impairments, language disorders, and illnesses change both the quality and quantity of learning opportunities for many children. With fewer meaningful interactions with people and things in our world, children with disabilities, or those at risk for disabilities, fall behind their peers in all developmental areas.

Therefore, the timing of intervention becomes particularly important when a child runs the risk of missing an opportunity to learn during the first few years of his or her life.

Note:

Throughout this manual the term Early Interventionist is used to globally describe the combination of services provided by DDSN providers. Early Interventionists provide the services of Family Training and Service Coordination in a blended manner, so in some areas this manual will refer to them as the Service Coordinator and still others as the Family Training provider. Both roles together make up the job functions of an Early Interventionist.

Statement of Philosophy

Introduction

The DDSN Early Intervention program has adopted a family-centered approach to organizing and providing assistance and support to families. This approach is based upon the principles of respecting every family's individuality. A child enrolled in the Early Intervention Program may create a need for parent-professional interaction, but should not remain the sole focus of services. Family-centered services respect the strengths and resourcefulness of all families and aim to support and encourage families in their efforts to independently meet the needs of their child with special needs and all its members in ways that they define as functional and appropriate for them. A philosophy of family centered services promises openness and flexibility to accommodate diversity in family beliefs, values, and functioning styles and the changes that families undergo continually as they cope with expected and unexpected life events.

The family-centered philosophy outlined in this Bulletin is based on the following assumptions:

- All people have strengths;
- All people benefit from support and encouragement;
- All people have different but equally valued skills, abilities and knowledge;
- All families have hopes, dreams and wishes for their children;
- All families are resourceful, but all families do not have equal access to resources;
- All families should be assisted in ways that help them maintain their dignity and hope;
- All families should be equal partners in the relationship with service providers; and
- Providers work to meet the needs of families.

SCDDSN providers are expected to adhere to the following principles of family-centered service planning and delivery. The illustrations of practice behavior that follow each principle provide clear illustrations of how all service providers are to interact with families from first contacts through transition from the Early Intervention Program.

Principle 1

The overriding purpose of providing family-centered help is family empowerment, which in turn benefits the well-being and development of the child. For example, providers

- are skilled in the use of effective helping practices and understand they are not rescuers of families;
- help families to feel hopeful;
- assist families to identify and successfully use their abilities and capabilities;
- assist families to make their own choices and decisions;
- respect families' decisions;
- suspend their judgments of families; assist families to plan for the future;
- assist families in becoming interdependent with communities of both informal and formal support, and
- credit families for successful goals.

Principle 2

Mutual trust, respect, honesty, and open communication characterize the family-provider relationship.
For example, providers

- use active/reflective listening skills;
- keep confidences;
- respectfully share with families in response to their concerns, complete and unbiased information;
- effectively use communication skills of dialogue and discussion;
- demonstrate care and concern for families;
- are cognizant and respectful of the culture, beliefs and attitudes of families as they plan and carry out all interventions;
- follow through in a timely manner, and
- are knowledgeable and credible in their actions.

Principle 3

Families are active participants in all aspects of services. The child's team makes all decisions within the constraints established by DDSN, DHEC and DHHS.
For example, providers

- function in a variety of roles (e.g., teacher, mentor, facilitator, mediator, coach, consultant, and advocate);
- plan interventions with the family that actively involves family members at a level of participation they choose;
- identify and use specific strengths of families as a resource for actively meeting identified needs;
- support and encourage decisions of families, and
- acknowledge families as equal partners.

Principle 4

The ongoing collaboration between families and providers is about identifying family concerns, priorities, hopes, needs, goals or wishes, finding family strengths, and the services and supports that will provide necessary resources to meet those needs.
For example, providers

- use problem solving strategies and techniques;
- listen to conversations and understand the relationship between expressed concerns and the real needs families could identify;
- help families to understand their own informal support networks and the potential resources these can provide;
- identify individual strengths of families and build upon these strengths to meet their needs;
- assist families in developing new strengths and abilities, and
- provide encouragement, feedback and guidance in helpful ways to families.

Principle 5

Efforts are made to build upon and use families' informal community support systems before relying solely on professional, formal services.
For example, providers

- understand the importance of natural networks of support in the health and well being of families;
- assist families to identify what resources their informal support networks can provide to meet specific needs or concerns;
- help families learn to communicate and advocate on behalf of their family;
- facilitate contacts between families and their communities to meet their needs through informal resources;
- share information about all community services and the resources they might provide, and
- help agencies and formal service providers clearly identify what resources they offer families.

Principle 6

Providers across all disciplines collaborate with families to provide resources that best match what families need.
For example, providers

- are competent in child development, family dynamics, and their professional specialty;
- have the skills to work in transdisciplinary teams;
- include and consider families as equal team members;
- are flexible and can function in a variety of roles;
- can cross agency boundaries and clearly understand each agency's resources, and
- present options of services and resources to families for their choice.

Principle 7

Support and resources are flexible, individualized and responsive to the changing needs of families.
For example, providers

- develop procedures that are simple and easily understood by families and other providers;
- reduce obstacles that prevent families from receiving immediate assistance;
- create a welcoming atmosphere for families;
- ensure that contacts with families happen frequently and support the development of a relationship between the provider and the family;
- arrange visits with consideration for family schedules and expectations;
- document information in a way that is reflective of the frequently changing needs and concerns of families;

- work together with families to individually design each specific intervention plan of action, and
- allow families to evaluate the success of all intervention goals.

Educational Requirements

Early Intervention Supervisor (Service Coordination/Family training Supervisor):

Minimum Bachelor's degree:

- Child/Human Development
- Education: Early Childhood, Special Education, Early Childhood Special Education, or Elementary Education
- Family and Consumer Sciences
- Licensed Practitioner of the Healing Arts (all)
- Psychology
- Public Health
- Social Work
- Sociology

And, either:1 year of experience in the field of early childhood education, OR 1 year experience working with infants and toddlers, OR 1 year experience with children age birth to 5 years with disabilities **and** 1 year of case management experience.

Early Interventionist (Service Coordination/Family training):

Minimum Bachelor's degree:

- Child/Human Development
- Education: Early Childhood, Special Education, Early Childhood Special Education, or Elementary Education
- Family and Consumer Sciences
- Licensed Practitioner of the Healing Arts (all)
- Psychology
- Public Health
- Social Work
- Sociology

And, either:1 year of experience in the field of early childhood education, OR 1 year experience working with infants and toddlers, OR 1 year experience with children age birth to 5 years with disabilities.

Roles and Responsibilities

Introduction:

Delineation of roles and responsibilities for the Early Intervention program is outlined on the following pages.

Responsibilities of SCDDSN:

1. Ensure compliance with all federal and state early intervention regulations as outlined in the Early Intervention Manual as well as the BabyNet Policy and Procedure Manual;
2. Establish general policies and procedures for the early intervention system within DDSN;
3. Integrate family centered philosophy into planning, policies and procedures, and administration of the Program;
4. Provide oversight and support needed by early intervention providers to fulfill their responsibilities;
5. Develop and implement interagency agreements with other state agencies and private organizations to ensure the most effective integration of available resources and services;
6. Identify unmet systemic early intervention needs and develop plans to address these needs;
7. Provide training and technical assistance for all public and private providers of early intervention services;
8. Ensure involvement of parents and consumers in policy and procedure development;
9. Provide ongoing evaluation and monitoring of the early intervention system; and
10. Assure available resources are allocated in an equitable manner.

Responsibilities of Provider agencies:

1. Ensure the implementation of all components of the Early Intervention manual for eligible children and their families;
2. Comply with all early intervention policies and procedures as outlined in the Early Intervention manual as well as the BabyNet Policy and Procedure Manual;
3. Adhere to the philosophy outlined in this manual during all actions and interactions related to the provision of services to children and families and to the local administration of early intervention services; and
4. Ensure that services as outlined in the child's IFSP/FSP are rendered in accordance with current program policy and that they include parent participation;

5. Work collaboratively with all community service providers;
6. Provide personnel and other support to the BabyNet Coordination teams to ensure collaboration at the local level between all agencies providing services to children; and
7. Collaborate with the local Health Departments and the Office of Education agencies to develop comprehensive procedures for responding to referrals and in the provision of early intervention services.

Child Specific:

1. Coordinate the referral process for all children, and pursue eligibility for children when appropriate;
2. Provide early intervention services and supports, assessment, service coordination and family training, as necessary;
3. Ensure designation of a Service Coordinator (EI/SC)for each child and family;
4. Maintain one record for each enrolled child that includes all required documentation.
5. Ensure that all eligible children have an IFSP/FSP and that all services and supports are provided in accordance with this Plan;
6. Coordinate and ensure resolution of child and family complaints; and
7. Assist families with referrals to other community agencies and programs as appropriate.

Early Intervention Supervisor Roles and Responsibilities

The Early Intervention Supervisor is a trained and qualified specialist in Early Intervention Services, serving children age birth to five years and their families. The Early Intervention Supervisor has the responsibility of monitoring and assisting Early Interventionists in the provision of service coordination and family training services and consulting with the Early Interventionist on an individual basis to ensure quality services are being rendered in accordance with all applicable standards. The Early Intervention Supervisor also communicates with the Early Interventionist regarding changes in service coordination and family training policies and procedures.

Overall roles and responsibilities of Early Intervention Supervisors include:

1. Review a minimum of two files per Early Interventionist per month to ensure quality and compliance with DDSN and Medicaid policies;

2. Contact a minimum of one family per Early Interventionist per month to determine if the needs of the child/family are being met;

3. Attend and document at least one home visit per quarter with each Early Interventionist to ensure quality and compliance with DDSN and Medicaid policies;

4. Assure that services are provided as identified on the IFSP/FSP;

5. Assure that all required training is completed within outlined timeframes. This should include DDSN required training as well as any on the job training. Additionally, required training will be assigned to each Early Interventionist and Early Intervention Supervisor by Team for Early Childhood Solutions (TECS) based on the core job functions;

6. Consult with agency director or designee on Early Intervention program needs to ensure supports are available to children and families;

7. Complete an annual job performance review for each assigned Early Interventionist based on objective/measurable goals;

8. Assure service coordination and family training are offered and provided to children during Early Interventionist absences (if the EI is going to be absent more than a month) and/or vacancies. This includes making arrangements with other providers or providing EI services directly;

9. Conduct special circumstance reviews when routine monitoring suggests poor quality of services; and

10. Document the results of the special circumstance reviews and develops with the Early Interventionist an action plan for correcting concerns noted.

Note: If a contracted provider employs one staff member, they are required to obtain supervision from an outside source.

Credential and Required Training for all Early Interventionists and Early Intervention Supervisors

With funding from the U.S. Department of Education, Office of Special Education Programs (contracted through BabyNet), the Team for Early Childhood Solutions (TECS) provides technical assistance in support of the Comprehensive System of Personnel Development (CSPD) for South Carolina's system of early intervention services under Part C of IDEA. They also assist the lead agency in assuring that South Carolina's early intervention personnel meet state standards by maintaining and reviewing applications for the BabyNet Credential for Part C system personnel.

All Early Intervention staff, including supervisors, must submit an application for the South Carolina Infant toddler Credential to the Team for Early Childhood Solutions (TECS) office within 2 weeks of employment or upon being assigned the aforementioned responsibilities. Full procedures for Credentialing can be found on the TECS' website at http://www.sc.edu/tecs. After submitting the initial application, it is required that the Early Interventionist or Early Intervention Supervisor submit information to TECS regarding changes that occur as a result of their staff getting married, being terminated, etc. This is required to ensure that the Credential data base is kept current.

Once TECS receives the Credential Application TECS will inform the Early Interventionist the required training modules associated with their roles and responsibilities. Each Early Interventionist must complete the assigned training modules (web-based) and pass the competencies which correlate to each module within 18 months. As updates or changes are made to specific modules, Early Interventionists will have 90 days to complete the module update to maintain their credential. If an Early Interventionist is having difficulty passing the competencies, a professional development plan will be established by TECS for that Early Interventionist.

A Training Checklist is attached outlining training required within 30 and 60 days of employment as well as recommendations regarding ongoing professional development updates that are optional for providers. See Attachment #1.

Training Requirements

Upon Hire:

New employees, full and part-time will receive a minimum of 40 hours of training. This training should include training provided within the first 30, and 60 days. Providers are encouraged to use all training methods to include, shadowing another employee, conference attendance, webinars, etc. See Attachment 1 for required training checklist.

Annually:

All staff are required to receive an additional 10 hours of job related training annually. Staff meetings, workshops and conferences may be considered in meeting this requirement. The TECS training modules should not be considered part of this 10 hour training requirement. See Attachment 1 for required training checklist.

Early Intervention Training Checklist

Topics	30 days	60 days	Date Completed	Update Required
Overview:				
1. Overview of SCDDSN, BabyNet, Local DSN Boards and DDSN Private Providers	**X**		_____	
2. Policies and Procedures of DDSN and the Board	**X**		_____	
3. Overview of service population-(MR, Autism, HASCI, Down Syndrome, Cerebral Palsy, Seizures)	**X**		_____	
4. Family Centered Practices/language	**X**		_____	
5. Confidentiality, HIPAA, FERPA	**X**		_____	Annual
6. Certification in Infant/Child CPR	**X**		_____	Annual
7. First Aid	**X**		_____	3 years
8. Bloodborne Pathogens (OSHA)	**X**		_____	Annual
9. Abuse and Neglect	**X**		_____	Annual
10. Safety Practices • Home visits • Transportation • Disaster preparedness • Fire Safety	**X**		_____	PRN
11. Defensive Driving(only required if driving agency vehicles)				Every 3 yrs
Required Training: EI Specific				
1.) Role of an Early Interventionist	**X**		_____	
2.) The Early Intervention Manual including:	**X**		_____	
a. Working with families				
b. Use of jargon				
c. Referrals				
d. Intake activities				
e. Obtaining and releasing information				
f. Eligibility Determination Process and Procedures				
g. Curriculum Based Assessments				
h. IFSP/FSP Development and teams/IFSP/FSP reviews				
i. Goal Development				
j. Facilitation (3-6)				
k. Choice of providers				
l. Family Training				
m. Service Coordination				
n. Genetics referrals				

Topics	30 days	60 days	Date Completed	Update Required
o. Critical cases p. Respite and Family Support Funds q. Advocacy • Pro-Parents • Family Connections 3. Early Intervention Key Indicators 4. Overview of BabyNet a. IDEA b. SPOE Process c. Authorizing services 5. Critical Incidents	 **X** **X** **X** **X**		_____	
Required Training: Overview of Financial Information 1.) MR/RD Waiver(training must occur **before** EI serves an MR/RD waiver enrollee) 2.) Budgeting/Capitation 3.) TEFRA 4.) Medicaid 5.) Social Security a. SSI, SSA, SSDI 6.) ABC Block Grant	 **X** **X** 	 **X** **X** **X**	 _____ _____ _____ _____ _____	
Required Training:Monitoring 1.) Appropriate and effective monitoring 2.) Monitoring schedules 3.) Life changing events 4.) Indicating progress/no progress	 **X** **X** **X** **X**		 _____ _____ _____ _____	
Required Training: Record Keeping and Documentation 1.) Record Keeping 2.) Record Security 3.) Contents of Record 4.) Purging procedures 5.) Reportable vs. Nonreportable 6.) Closed cases 7.) Documentation a. Service notes b. Late entries c. Abbreviations d. Errors e. Signatures	 **X** **X** **X** **X** **X** **X** **X**		 _____ _____ _____ _____ _____ _____	

Topics	30 days	60 days	Date Completed	Update Required
Optional Training: Ongoing Professional Development: 1.) Communication Skills 2.) Time Management/Organizational Skills 3.) Cultural Diversity 4.) Conflict Resolution 5.) Stress Management 6.) Developing New Resources 7.) Signs and Symptoms of Mental Illness 8.) Positive Behavior Supports				

Eligibility for SCDDSN Services

The process of determining eligibility for SCDDSN services begins with screening and ends with notification of the parent/legal guardian of the final eligibility decision by DDSN including any appeals that might be initiated. Activities include gathering information, which may support DDSN eligibility from the legal guardian/family members, current and former service providers, and others who know the child. Information may be gathered by mail or electronic correspondence, telephone interview, or face-to-face interview.

If a child three years of age or older is referred for DDSN eligibility and family training is **not** a need for the child/family, the eligibility process will be completed by the service coordination department. During the screening process each parent of a child under the age of 5 years, will be informed or educated about the service of Family training by the screener.

Screening:

DDSN uses standardized tools, methodology, and specifically trained staff to screen those who are potentially eligible for services. Only those who are trained may complete screenings, and only HOME-BOARD employees will be trained to be screeners. Contracted providers must contact or have the family contact the home-board in which they reside to be screened for DDSN eligibility.

All children (three to five) must go through the screening process if DDSN eligibility has been identified as a need for the child/family. If a child three to five is "screened in, the Early Interventionist can proceed with the submission of an eligibility packet to the Consumer Assessment Team (CAT). If the child is "screened out, the family should be provided information about other community resources that may be of assistance. During the screening process the screener will offer the family a choice of Early Intervention providers. This choice is documented in the disposition section of the screening tool. If the family chooses a provider other than the home-board the screener will contact the contracted provider to ensure that they will accept the referral and will transfer the individual to the chosen provider on CDSS.

For the children birth to three who wish to pursue DDSN eligibility, the EI has two options as to how to proceed. The EI can either move forward with the submission of the eligibility packet or complete the DDSN screening process if the Early Interventionist has reason to believe that the child may **NOT** be DDSN eligible. If the screening process is not completed the Early Interventionist must still establish residency through the use of the Early Intervention Residency Questionnaire (Attachment #1). In addition they must offer the choice of providers using the Acknowledgment of SC/EI Choice form (Attachment #1 in Procedural Bulletin 7). If a child (birth to three) is "screened out" they can continue to receive Service Coordination/Family training as long as they continue to

be eligible for BabyNet. If the child meets the residency requirements the Early Interventionist should proceed with the CAT packet.

Intake:

Once a child has been "screened-in" the Early Interventionist will begin the process for establishing eligibility or "intake". The following steps should be completed during the intake process;

1. For children birth to three, the Early Interventionist must have a Service Agreement and Permission to Evaluate (Attachment #2) signed by the child's parent or legal guardian (for a child in DSS Foster Care, the Foster Parent may sign the Service Agreement on the child's behalf) once the need for a DDSN service is identified, but no later than 10 working days. For children three to five, the EI must have the Service Agreement signed within ten working days of the completion of the screening disposition. The initial FSP must be completed within 30 days from the offer of choice of provider during the screening process. Once the need for family training has been identified it should be provided (EI's should not wait for eligibility determination before providing this service).

2. Collecting any information to include birth records, medical records, therapy reports, Individual Education Plans, if applicable, and any other information that will assist with the eligibility determination.

3. Complete a Consumer Information Summary (CIS) to send to the Consumer assessment Team. See Attachment #3.

4. Assemble an Eligibility packet that will include; an Application of Eligibility Cover sheet (Attachment #5), the CIS, all pertinent records, and the IFSP/FSP. See Attachment #4 for Autism Referral form.

5. The Consumer Assessment Team (CAT) will review the eligibility packet. If needed, more information will be requested and a determination of eligibility will be made.

6. When an eligibility determination is made the CAT will update CDSS with the eligibility category and will fax the Early Interventionists an Eligibility Determination letter.

If a decision on eligibility has not been made within 3 months of the date the parent was offered a choice of provider during the screening process the Early Interventionist must meet with the Early Intervention Supervisor to discuss the child's situation. From this discussion, the supervisor may approve the extension of the timeframe for Intake completion for 3 additional months. These actions will be documented in the service notes including the reasons(s) for extension. If eligibility is not determined within 6 months of the date of referral the Supervisor/Director of Early Intervention must discuss the child's situation with the Executive Director to determine whether the process will continue or be terminated. This process can be continued, but reporting on Individual Service Report (ISR) must cease. This must be documented in the service notes.

*Children granted time limited eligibility for DDSN services as "either MR/RD Time-limited", "high risk infant" or "at risk" must be re-assessed by DDSN's Consumer Assessment Team for eligibility re-determination before eligibility expires. If a child is deemed "high risk" and their eligibility expires prior to the age of three, the Early Interventionist may still report the provision of services for that child as long as he/she is BabyNet eligible. If eligibility re-determination does not occur prior to eligibility expiration for children who are 3-5, service coordination and family training activities can be provided as identified on the IFSP/FSP but MUST not be reported on the ISR's.

Referring children to the Autism Division:

If Autism is suspected or has been diagnosed, the Early Interventionist should send a referral packet containing pertinent documentation and records including a "*Referral for Autism Division Evaluation, "DDSN Service Agreement and Permission to Evaluate" and "Authorization to Release and/or Obtain Information*" forms to the appropriate Autism Division office (e.g. Coastal, Midlands, Pee Dee and Piedmont) for a determination. If there are critical needs that must be addressed sooner than an Autism evaluation may be completed, the individuals Early Interventionist will need to contact the appropriate Autism Division Administrator to discuss the case. (See attachment 3, "Referral for Autism Division Evaluation" form).

Who is eligible for what services?

- If a child is eligible for DDSN services under the "High-Risk (0-2 years) category he/she may receive Family Support Funds, Respite, Center Based Child-Day services, Family training and Service Coordination. Once the "High-Risk" infant turns 3 years of age he/she may be considered "At-Risk" and will ONLY be eligible for Service Coordination and Family training and Federal Family Support (if all other criteria for that funding are met). Early Interventionists should educate families about these distinctions in order to prepare them for this transition of services.

- If a child is eligible for services under the category "MR/RD Time limited" he/she is eligible for ALL services including; Family Support (See attachment 1 for FSF Quick Reference Guide), Respite, Center Based Child-Day services, Family Training and Service Coordination. The child's eligibility must be reviewed prior to the expiration date listed on the eligibility certification letter.

- If a child has a vision and/or hearing impairment and receives services (FT/SC) from the South Carolina School for the Deaf and Blind (SCSDB) and DDSN services are identified as a need, (respite or family support funds) the DSN Board or Contracted Provider will provide Concurrent Service Coordination for DDSN services. The SCSDB Service Coordinator should forward all pertinent records, to include the IFSP, to the Early Interventionist. The Early Interventionist should follow the same eligibility process as described earlier in this Bulletin. Once DDSN eligibility has been established, the EI should request that the SCSDB Service Coordinator hold an IFSP review in order to add the DDSN services to

the "Other Services" section of the IFSP. If attempts to add the needed services to the IFSP fail, the EI should contact the Supervisor at SCSDB to ensure that the needed services get added to the plan.

- If a child is receiving services from SCSDB and the need for a MR/RD, HASCI, or PDD Waiver slot is identified, the EI will complete the waiver and/or eligibility process as a Concurrent Service Coordinator. At time of enrollment in the Waiver the Early Interventionist MUST then become the child's Primary Service Coordinator. The original IFSP should be forwarded to the EI from the SCSDB Coordinator. If the child is receiving Special Instruction from SCSDB they should continue to receive those services from them.

- Once the need for a MR/RD, HASCI, or PDD Waiver service has been identified or the family expresses an interest in or desire for the MR/RD waiver, the Early Interventionist must complete an application, without regard for the child's eligibility category. See MR/RD Waiver Manual for specifics about this process.

Early Intervention Residency Questionnaire

Child's Name:_____
Date of Birth:_____

This questionnaire is to be used for Babynet children who are pursuing DDSN eligibility. Check the appropriate description of the individual.

- ☐ The consumer is a child born in the United States (U.S.), and lives with parents who are U.S. citizens and reside in South Carolina (SC). Proceed with an eligibility packet.

- ☐ The consumer is a child with a SC Medicaid card. Proceed with an eligibility packet. (If screened in a copy of the child's birth certificate, birth records or SC Medicaid number will be required for intake packet to the Consumer Assessment Team (CAT)).

- ☐ The consumer is a child, not born in the U.S. Confer with CAT.

_____

Early Interventionist Signature **Date**

Family Support Funds
Quick Reference Guide

State Funding

High Risk 0-3 yrs	At-Risk 3-6 yrs	"MR" Time-Limited
Yes	**No**	**Yes**
Enrolled in MR/RD Waiver-**No**		
Enrolled in the PDD Waiver-**No**		

Federal Funding 3-21 yrs
Without an IEP

Enrolled in the MR/RD Waiver-**Yes**
Enrolled in the PDD Waiver-**Yes**
Enrolled in school-**No**
At Risk (3-6 yrs)-**Yes**

SOUTH CAROLINA
DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Service Agreement and Permission to Evaluate

I, _____ (print applicant's legal name), am requesting the following services from the South Carolina Department of Disabilities and Special Needs (SCDDSN)

☐ SCDDSN Eligibility Determination ☐ Other Evaluations and Services

I understand that SCDDSN may obtain and review existing available medical/service records and, if necessary, require psychological evaluations or other evaluations of me to establish or rule out my eligibility for the requested service.

I understand that if I meet the criteria for eligibility for any of the above services, my eligibility to continue receiving those services may be re-evaluated, particularly when there are indications of improvement in my ability to do things for myself.

I understand that being approved for SCDDSN eligibility does not guarantee that I will receive specific services as these will be dependent upon documentation of my need and upon availability of a program or service or availability of a program/service opening. I understand that in the absence of a program/service opening I may be placed on a waiting list for that program/service.

I further understand that if approved for SCDDSN eligibility and if I have a need for placement in a SCDDS-sponsored residential setting that such placement will be dependent upon demonstration of my need for placement and dependent upon the availability of a bed in a SCDDSN-sponsored residential setting most appropriate to my need.

I also understand that SCDDSN may bill private insurance, Medicare, Medicaid, and/or any other third party payer for any covered services provided by SCDDSN and that neither my parents nor my legal guardian (if either are applicable) will be held responsible for costs not covered by that payer.

_____ _____

Applicant's Signature ***Date***

_____ _____

Parent/Legal Guardian's Signature
(For applicant under 18 years or legally incompetent) ***Date***

ATTACHMENT #3

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
CONSUMER INFORMATION SUMMARY

☐ MR/RD DIVISION ☐ HASCI DIVISION

I. CONSUMER'S BIOGRAPHICAL INFORMATION

First/Middle/Last Name:	
Nickname: *(if applicable)*	
DOB:	SS#: *(must be submitted)*

II. SC/EI INFORMATION

DSN Board/Private Provider name:
E.I. Program Name: *(If applicable)*
SC/EI Name: *(please print)*
SC/EI office/cell phone:

III. TYPE OF REFERRAL *(check one)*

	NEW: *(First time referral to DDSN-screening should be enclosed)*
Referral source and relation to applicant:	

HASCI Information and Referral date: *(If applicable)*

	RE-OPEN: *(Eligible for DDSN services in the past-screening should be enclosed)*
When was the case closed?	
Why was the case closed?	
What was the eligibility category while open?	
Was eligibility time limited? ☐ Yes ☐ No	
Did you include a copy of the original eligibility paperwork in this packet? ☐ Yes ☐ No	
If No, explain:	

	TIME-LIMITED ELIGIBILITY: *(Eligible, but requires review prior to eligibility end date or category change from current status if new information exists that might warrant a change)*
What eligibility category does this consumer have now?	
What is/was the time limited due date?	
Are you submitting this file early in order to request a category change? ☐ Yes ☐ No	

If Yes, what is the new information you have submitted?
Have you included the original eligibility determination letter in this packet? ☐ Yes ☐ No
If No, explain:
Do you recommend continued eligibility? ☐ Yes ☐ No
Explain:

	RETURN: *(Unable to determine eligibility; file returned for further information and/or action from the SC/EI)*
What additional information have you attached to the Communication Exchange? *(Please be sure to return the entire file along with the requested new information)*	

	RE-EVALUATION: *(Re-visit prior ineligible determination or current eligibility status if there is evidence that the consumer may no longer qualify for DDSN services)*

If re-evaluation is requested for a reason other than ineligibility, please explain your rationale and list the documentation you have to support your request.

If re-evaluation is based upon a prior ineligibility determination, please note the date of ineligibility. *(Please include all prior ineligibility letters)*

Why was the person found ineligible?

Who is questioning the eligibility decision now and what is their affiliation to the applicant?

What new/additional information is included that supports your request for re-evaluation?

If reevaluation determination is/remains ineligible after CAT review, does the referring party want the file to be forwarded onto Central Office for Appeal at this time?

☐ Yes ☐ No

	APPEAL: *(Request for Central Office review after all available information has been considered by CAT and determination remains ineligible)*

Who is requesting the appeal and what is there affiliation to the applicant? *(Please be sure to include letter of appeal from either the referring party or the SC/EI.)*

IV. INFORMATION PERTAINING TO CHILDREN (0-18 YEARS)

Briefly summarize relevant social/family information. Include any social aspects that might influence the child's overall development *(e.g., living situation, family issues, abuse/neglect, substance abuse, non-compliance, legal involvement, other family members with disabilities).*

Were there significant pregnancy, delivery, or neonatal problems that resulted in neurological involvement?

☐ Yes ☐ No

(If Yes, please prove supporting documentation to include MRI's and CT SCANS)

For children birth to 6, are there significant developmental delays in at least three areas? *(Please circle all that apply.)*

Self-help Cognitive Expressive Language Receptive Language

Fine Motor Gross Motor Social

Are there significant behavior/emotional issues? ☐ Yes ☐ No
(If Yes, please explain and provide supporting documentation, if applicable)

V. INFORMATION PERTAINING TO ADULTS (OVER 18 YEARS)

Briefly summarize relevant social/family information. Include any social aspects that might influence the person's overall development *(e.g., living situation, family issues, abuse/neglect, substance abuse, non-compliance, legal involvement, other family members with disabilities).*

If you suspect Mental Retardation, did you establish that onset occurred before age 18? ☐ Yes ☐ No

If you suspect a Related Disability, did you establish that onset occurred before age 22? ☐ Yes ☐ No

If no formal records of onset could be located, is there informal or descriptive information available to suggest onset? ☐ Yes ☐ No
Please explain:

Are there significant behavioral/emotional issues that might impact eligibility *(mental health/drug & alcohol)?* ☐ Yes ☐ No
(If Yes, please explain and provide supporting documentation, if applicable)

INFORMATION PERTAINING TO BOTH CHILDREN AND ADULTS

List all current diagnoses the person has been given by various professionals:

Does the person take medication? ☐ Yes ☐ No	
Condition	***Medication/Dosage***

Has there been a traumatic head or spinal cord injury or similar non-traumatic illness or condition? ☐ Yes ☐ No *(If No, please disregard the following questions that are marked with an asterisk*)*
*If Yes, please describe:
*Are onset records included in this packet? ☐ Yes ☐ No
*If No, what supporting documentation is included in this packet?
*Is the Substantial Functional Limitations Inventory (SFLI) or other Functional Inventory Tool current within 30 days? ☐ Yes ☐ No
*If No, is an updated/amended (SFLI)/other Functional Inventory Tool being submitted? ☐ Yes ☐ No
If No, why not?

Is Autism suspected? ☐ Yes ☐ No *(If No, please disregard the following questions that are marked with an asterisk*).*
*If Yes, are reports/behavioral observations that support the individual's autistic-like behaviors enclosed? ☐ Yes ☐ No
*Has the consumer been referred to the Autism Division? ☐ Yes ☐ No ☐ N/A
*If Yes, please give current status of that referral: *(If necessary, please refer to the appropriate regional Autism Division for an update on status)*

*If No, why has a referral not been made?

What services do the applicant/family want?
Are service needs described as urgent by the referring party? ☐ Yes ☐ No
If Yes, what is the urgency?

Having observed this person, reviewed all the enclosed records, and considered DDSN eligibility criteria, summarize your impressions so that we may gain a clear picture of this person, his or her needs and relevant service concerns.

Referral for Autism Division Evaluation

Name of individual referred: _____DOB:_____

Name of family member(s) or guardian(s): _____

Home address: _____

Home county: _____

Telephone #: _____ Work # : _____ Best time to call: _____

County: _____ Soc. Sec. #: _____ Medicaid #: _____

Other Medical/Health Insurance Company: _____

SC/EI Name: _____ Organization:_____ _

PO / Street Address: _____

City:_____ Zip: _____ County: _____ Phone:_____ Today's date: _____

Please include/attach the following information if available:

_____Consumer Info. Summary
_____POS/PCP/IFSP
_____Medical evaluations
_____Service Agreement form
_____Social History (if available)
_____Psychological assessment; behavioral program if relevant
_____IEP/IPP/Hab Plan
_____Genetics screening
_____DDSN eligibility letter (if DDSN eligible)
_____Other _____

Is documentation of prior diagnosis of Autism included? _____yes _____no
Reason for referral: _____

_____

_____

Rate level of need for Autism Division assessment/services:

_____1. Need is immediate AND critical (note reason in comment section)
_____2. Need is immediate, but NOT critical
_____3. Need is NEITHER immediate, nor critical

Additional comments:_____

_____

What is this person's eligibility status with DDSN?

_____Eligible _____ (date determined) _____(category)
_____Eligible, time limited _____ (re-eval date)
_____Not eligible _____
_____Pending with CAT _____ (date sent to CAT)
_____Not sent to CAT

_____First Referral, ____ Referred Previously _____(note if more than 2nd)

Autism Division use only
Referred to:_____

SCDDSN
CONSUMER ASSESSMENT TEAM

APPLICATION FOR ELIGIBILITY

COVER SHEET

Name: _____ *County:* _____

SC/EI: _____ *Board/Program*: _____

☐ ***New Consumer***

☐ ***Return***

☐ ***Re-open***

☐ ***Review of Time Limited Eligibility***

☐ ***Re-evaluate***

☐ ***Appeal***

☐ ***Other***

Comments:

_____

_____

_____

_____ _____

Service Coordinator/Early Interventionist ***SC/EI Supervisor***

Service Coordination

The Department of Disabilities and Special Needs provides early intervention services to young children in a blended model, meaning that the child's service coordinator is also their family training provider. This model was chosen in order for children and families to experience more continuity of service and endure less stress because fewer people are entering their homes.

The Service Coordinator is the person who acts as the coordinator of a child's and family's services and works in partnership with the family. Service Coordinators must assure that children/families have access to a full array of needed services including medical, social, educational, or other services. The Service Coordinator is responsible for identifying individual needs, strengths, and resources; coordinating services that are supportive, effective and cost efficient to meet those needs; and monitoring the provision of those services. Service Coordinators must partner with families in order to empower them. Through this partnership, families can learn to make decisions and coordinate their own care and services. While this removes control from the professional, it promotes better decision making and mastery of care by the family.

Overall Roles and Responsibilities of Service Coordinators include:

1. Assuring that all required training is completed within outlined timeframes. This should include DDSN specific information as well as any on the job training. Required training will be assigned to each Early Interventionist by TECS based on the results of the Early Intervention Credential application;

2. Assisting, if assistance is needed, the parent/legal guardian in locating a primary care physician for their child unless it is the documented expressed wish of the parent/legal guardian not to have one;

3. Assisting the family with the location of information or making referrals as needed for preventive measures, medical evaluations, and treatment so that the parent may make informed healthcare decisions for their child;

4. Having a Service Agreement signed by the child's parent or legal guardian (for a child in DSS Foster Care, the Foster Parent should sign on the child's behalf) once the need for a DDSN service is identified, but no later than 10 working days. A new Service Agreement must be obtained if there is a change in legal guardianship or each time a child's has been closed and re-opened to the Early Intervention Program;

5. Establishing on CDSS a record with required Intake information as soon as it is available (may be as soon as initial referral contact) but no later than 3 working days after obtaining a referral. CDSS must contain current demographic information, support services information, HCBW services information, other agency information and eligibility status information. All changes must be made to CDSS in 3 working days;

6. Developing, coordinating, reviewing and revising the IFSP (Individualized Family Service Plan) and the FSP (Family Service Plan) to address family and child strengths and needs identified by the family;

7. Coordinating transitions to and from other community services (i.e., between early intervention and public school, Head Start, Early Head Start, and child care in the community);

8. Attending interagency staffings and meetings;

9. Documenting all aspects of early intervention activities including: written plans, reports, progress and follow-up towards goals;

10. The documentation of family training and service coordination must be kept separate. Despite times when service coordination and family training are provided simultaneously, they are two different services and must be documented as such;

11. Signing all service notes, family training sheets, and IFSP's/FSP's;

12. Reporting activity on the Individual Service Report (ISR);

13. Attending court ordered hearings or other legal proceedings;

14. Completing all required actions as outlined in the MR/RD Waiver manual when a service funded by the MR/RD Waiver is identified as a need or the family expresses an interest in or a desire for waiver enrollment;

15. Assisting family members with locating resources to meet their child's needs;

16. Closing, transferring and maintaining records according to Procedural Bulletin #13 of this manual;

17. Arranging, linking, integrating, coordinating, and monitoring the delivery of services, including assessment, medical, and health services, across agency lines, and serving as a liaison between parents and other service providers;

18. Serving as a single point of contact in helping the parent to obtain the services and assistance they need;

19. Assessing child and family concerns, priorities, and resources on a regular basis; assessing the child's development and monitoring the child's progress toward goals;

20. Initiating the IFSP/FSP process and taking responsibility for the development, implementation, and reviews of the IFSP/FSP;

21. Assisting parents of eligible children in identifying and gaining access to the early intervention services and other services identified in the IFSP/FSP;

22. Facilitating the timely delivery of available services and monitoring the provision of services;

23. Exploring appropriate services and situations needed to benefit the development of each child being served for the duration of the child's eligibility;

24. Establishing and maintaining communication among all parties involved with the child and family;

25. Ensuring that procedures are followed related to communicating with children and families in their native language or primary mode of communication, confidentiality of information, and parental access to and amendment of records are followed;

26. Ensuring appropriate and timely documentation, including the reporting of relevant data and the submission of required forms, and other documentation to DDSN and BabyNet as required or appropriate;

27. The Early Interventionist recognizes signs and symptoms of illness and takes action accordingly;

28. Recognize and assist the family in assuring environments are free of fire and safety hazards. The attached Safety Checklist should be completed annually. This form can be modified however it must include all of the same information. (See Attachment # 4)

29. Recognizing signs and symptoms of abuse and neglect and when identified takes action accordingly; and

30. Offering and documenting the choice of providers at time of intake and at least annually thereafter at a minimum. (See Attachment #1)

31. When serving a child concurrently,as is the case with SCSDB, the EI is required to have quarterly contact with the family.

Specific Roles and Responsibilities of Service Coordinators include:

First Contacts

1. Contacting all children/families newly referred within three (3) working days after obtaining a referral;

2. Explaining the Program including the eligibility determination process;

3. Ensuring completion of the Screening process by a Home-board screener, at which time choice of Service Coordination provider is offered;

4. Explaining service options and the intake process, gathering necessary intake information, getting the Service Agreement signed within 10 working days of choice being offered during the screening process; and

5. Beginning a family directed identification of family needs, strengths, concerns, priorities and resources, activities and places.

Eligibility Determination

1. Collect information including birth records, medical records, therapy reports, Individual Education Plans, if applicable, that will assist with eligibility determination;

2. Completing a Consumer Information Summary (CIS) to send to the Consumer Assessment Team;

3. Assembling an Eligibility packet that will include; an Eligibility Cover letter, the CIS, all pertinent records, and the IFSP/FSP;

4. Monitoring the eligibility timeline and recording documentation regarding the process and any delays (Further details outlined in Procedural Bulletin #6.);

5. Making referrals to other community resources, as appropriate.

Curriculum Based Assessment

1. Completing Curriculum Based Assessment and interpreting results to develop the plan and identify services that are potentially needed. (Further details outlined in Procedural Bulletin #8).

Individualized Family Service Plan (IFSP)/Family Service Plan (FSP)

1. Ensuring completion of initial and annual plans. For specific information regarding the completion of the IFSP document, please refer to the BabyNet Policy and Procedure Manual. For specific information regarding the completion

of the FSP document, please refer to Procedural Bulletin #11.

Specifics regarding Transitioning to Service Coordination

1. The Level I/II Assessment (See Attachment #2) must be completed by the Early Interventionist prior to initiating transfer to Service Coordination. If the child's assessment indicates the need for Level I Service Coordination they should be transitioned to Service Coordination as soon as possible. When a child is transitioned to Service Coordination, every effort should be made to schedule a joint home visit with the new Service Coordinator. During that visit both staff should discuss the changes that the family will experience as a result of the move to Service Coordination. If the assessment indicates the need for Level I Service Coordination, but the family still desires Level II, the Service Coordinator should contact the Office of Children's Services to obtain approval for that child to move to Level II Service Coordination. The families choice to move to Level II Service Coordination would then be documented on the Agreement for Level II Service Coordination(Attachment #3)

2. If the Level I/II Assessment indicates the need for Level II the Early Interventionist must have the family sign the Agreement for Level II Service Coordination (Attachment #3), then the case should be transferred to Service Coordination and it is the responsibility of the Service Coordinator to contact the Office of Children's Services to obtain approval for that child to move to Level II Service Coordination.

Overall Roles and Responsibilities when Transitioning to Service Coordination

1. Educating the parent regarding options, transition process, etc.;
2. Functioning as a liaison between the child and parent and the next program, as appropriate, including making referrals, arranging transition planning meetings, providing information to the parent on the next program; and
3. Working with the parent and service providers to arrange for appropriate services to continue for the child after his third birthday, as needed.

The following is a list of resources that are often used when serving young children:

- Children's Rehabilitative Services
- Women, Infants and Children (WIC)
- ABC Special Needs Program
- Community Long Term Care (Children's PCA)
- Pro-Parents
- DDSN's Practical Guide to Services
- SC Safe Kids
- USC Center for Disabilities Resources

Acknowledgement of SC/EI Choice

By signing this form I understand and acknowledge that my rights regarding choice of providers have been explained, and a list of qualified providers has been made available to me. I have reviewed the available options and have selected the provider listed below. I understand that at any time, if I am dissatisfied with my chosen provider, I can elect to change to another provider if available. My choice of qualified provider is:

Service Coordination: _____

Early Intervention: _____

_____

Consumer (if age 18 or older) Date

_____

Parent/Legal Guardian (if applicable) Date

_____

Service Coordinator/Early Interventionist/Other Date

Updated Choice of SC/EI Provider

Provider: _____

_____

Consumer/Parent Signature Date

_____

Service Coordinator/Early Interventionist/Other Signature Date

Provider: _____

_____

Consumer/Parent Signature Date

_____

Service Coordinator/Early Interventionist/Other Signature Date

Updated 1/19/05
Procedural Bulletin # 7

LEVEL I/LEVEL II SERVICE COORDINATION ASSESSMENT

This assessment is to determine if there is an ongoing need for service coordination services, and should be completed in the following instances: 1) new intakes determined eligible for DDSN services, 2) children transferring from EI to service coordination, and 3) consumers transferring from Level I to Level II or visa versa.If any **'YES'** answers are given to the following questions, there is an identified need for ongoing servicecoordination and Level I service coordination is **required**. If 'YES' answers are not given and there is noidentified ongoing need for service coordination, then Level II service coordination must be considered. **(Note: This assessment is not required to be completed annually.)**

YES ☐ NO ☐ 1. Is the person currently going through the DDSN eligibility process?
YES ☐ NO ☐ 2. Is there an identified ongoing need for service coordination? (such as the need for intensive treatment or services, parent with limited skills or disability that is unable to provide adequate care/supervision of services and needs, undiagnosed condition requiring further evaluation, current difficulties with the school district regarding placement and/or other related services, DSS being involved currently or in the recent past for allegations of abuse, neglect or child endangerment, etc.)
YES ☐ NO☐ 3. Is the person currently on the DDSN critical waiting list?
YES ☐ NO☐ 4. Does the person currently receive MR/RD or HASCI Waiver services?
YES ☐ NO☐ 5. Does the person live in an alternative placement or a DDSN supported placement other than an ICF/MR?
YES ☐ NO☐ 6. Is the person being concurrently served by DJJ? (unless otherwise approved by DDSN)
YES ☐ NO☐ 7. Does the person live in a nursing home? (unless otherwise approved by DDSN)
YE☐ S NO☐ 8. Does the person live in a CRCF/boarding home? (unless otherwise approved by DDSN)
YES ☐ NO☐ 9. Is the person currently categorized as 'At Risk' or 'Time-Limited Eligibility? (unless otherwise approved by DDSN)
YES☐ NO☐ 10. Does the person have medical (including genetic) conditions requiring consistent, coordinated care by general or specialty physicians, therapists, and other allied health professionals that demonstrate a need for monitorship?
YES☐ NO☐ 11. Is there a presence of health risk indicators (such as high blood pressure or unmanaged diabetes); or has the person/guardian expressed health or safety concerns that neither they nor others have been able to resolve, that they appear not to have recognized or are not addressing or refusing to address?
YES☐ NO☐ 12. Is the person engaging in behaviors with serious health, safety, or legal consequences?
YES☐ NO☐ 13. Is the person a threat to the health and safety of others?
YES☐ NO☐ 14. Are there circumstances that are a threat to the current residential placement (such as behavioral issues or lack of supervision), or that threaten the continuation of care in the near future by the primary caregiver (such as health or aging issues)?
YES☐ NO☐ 15. Is there a threatened loss of economic support for the person or primary caregiver?

Consumer's Name: _____

Date

_____

Service Coordinator/Early Interventionist/Other **Date**

Name: _____
SSN:_____

Agreement for Level II Service Coordination

I understand that, by signing this form, I agree that my situation is stable and my needs are being met by myself and/or family with no ongoing Service Coordination intervention needed.

I also understand that Level II Service Coordination means that I have access to my Service Coordinator as needed or requested, or at an annual contact initiated by my Service Coordination provider.

Upon signing of this form by a SC Supervisor, my case remains open but is classified as Level II. This means that:

1. I will be contacted by a Service Coordinator or other provider staff once a year to determine whether there have been changes in address, telephone number, or primary contact person, and to generally determine how I am doing. I will be informed of available service providers and given the opportunity to select another one if I choose to do so.

2. I may contact the Service Coordinator anytime I need assistance at the following location:

   Service Coordinator: _____
   Address: _____
   _____
   Phone:_____

   If the above Service Coordinator is not available, I have been instructed to ask for the Service Coordination Supervisor.

3. I realize that an annual plan will not be developed by a Service Coordinator.

_____
Consumer Date Legal Guardian Date

_____ _____
Service Coordinator/Early Interventionist Date SC Supervisor Date

Updated 1/19/05
Procedural Bulletin #7
Attachment #3

Safety Checklist

The Early Interventionist should review the health and safety checklist with the parent/caregiver. Any answer that is checked no shows a possible danger for the family. This should be discussed and every possible effort should be made to "remove" the potential danger.

Child's Room

Yes	No	
☐	☐	Does the child have a crib or a safe place to sleep?
☐	☐	Are crib slates no more than 2 3/8 inches apart?
☐	☐	Does the crib mattress fit the crib snuggly?
☐	☐	Is the child's crib located near a window?
☐	☐	Is the child's bed/crib placed away from radiators or other heated surfaces?

Kitchen

☐	☐	Are the kitchen cabinets equipped with safety locks?
☐	☐	Are cleaning products kept out of the child's reach?
☐	☐	Is the high chair placed away from the stove or other hot appliances?
☐	☐	Are knives and other sharp items kept out of child's reach?

General Precautions

☐	☐	Is there a fire extinguisher in the home?
☐	☐	Are there smoke detectors in the home?
☐	☐	Do you have an emergency exit plan to use in case of fire? If not, a plan is advised.
☐	☐	Does the child have a car seat? If yes, is it appropriate for that age child?
☐	☐	Are televisions placed in locations where they are likely to fall?

Home Safety Review

The review of the following safety checklist was completed with my early interventionist on this date.

_____

Parent/Caregiver Date

_____

Witness Date

Curriculum Based Assessment (CBA)

Assessment is an important event for families and their children; assessment results are used to include or exclude children from specialized interventions that can affect their developmental outcomes. Assessment is critical for program planning, monitoring progress and program evaluation. The developmental assessment process is used to determine strengths and needs of a child. Assessment is an ongoing process. Developmental assessments are timely, comprehensive, and multidisciplinary and should include the following:

- Analysis and profiling of developmental competencies
- Adaptation/Modification of items
- Instruct the Early Interventionist in assisting the family in creating learning opportunities by imbedding curriculum items in naturally occurring routines, activities and settings (known as activity-based learning)
- Monitor incremental gains in progress
- Facilitate collaboration among team members
- The choice of which assessment tool to be used is determined by the professional recommendations of the Early Interventionist
- Assessment tools are used that are specifically designed to assess a child's developmental level. As a child progresses, appropriateness of an assessment tool will be evaluated by the Early Interventionist and parent/legal guardian and changed as needed. All children receiving special instruction **must have an assessment** completed at least annually or more often if changes warrant, i.e., meeting all outcomes, medical procedures resulting in significant regression. Examples of assessments include psychological evaluations, Individualized Education Program (IEP'S), and curriculum based assessments or any combination of these tools. The child must be evaluated in all domains
- Families' expectations for their child are noted in service notes and/or IFSP/FSP.

Specific EI responsibilities related to assessment include:

1. Using the most appropriate assessment instruments to assess a child's developmental level;
2. Ensuring that the CBA is completed before the annual plan. It is recommended that the CBA process start 30 days prior to the plan due date;
3. Ensuring that the assessment is current, within 1 year, and updated as needed;

4. Ensuring the assessment reflects the child's:
    - cognitive development;
    - gross and fine motor development;
    - communication;
    - emotional and social development;
    - self-help skills;
    - physical development including information from medical and family history, along with current health status, is used to determine present physical condition;
    - vision-any relevant vision information (should be included in the child's FSP);
    - hearing-any relevant hearing information (should be included in the child's FSP).

SECTION 6B: ASSESSMENT OF CHILD'S PRESENT LEVEL OF FUNCTION	
Date of IFSP	Child's Name
Child's ☐Chronological or ☐Adjusted Age at time of CBA: _____ years _____ months	
CBA Tool: ☐ AEPS ☐ HELP ☐ The Oregon Project ☐ The INSITE Development Checklist	Name and agency of CBA Provider *please print*:
Overall strengths of child, successful strategies used in the assessment, and factors that may have affected assessment process ***Provide a brief narrative of the assessment situation, and participants. Include any unique strengths the child demonstrated in performing assessment items, strategies found to be successful with the child in conducting the CBA, and any factors that may have affected the child's performance during the assessment process.*** ***All domains must be assessed and reported for development of the Initial and Annual IFSP.***	
CBA Results for Social –Emotional Domain	
Social-emotional skills child currently demonstrates: ***For each domain of development, the following must be reported:*** ***Skills the child currently demonstrates: (AEPS: 2s, HELP: +s): List 3-5 CBA items representing the highest level of development across all appropriate strands within this domain.***	
Skills newly learned/emerging: ***Skills newly learned or emerging: (AEPS: 1s, HELP: +/-s): List 3-5 CBA items representing newly learned skills across all appropriate strands within this domain. If using the HELP, include only the skills scored as a +/- that appear within 3 months on either side of current level of development.***	
Skills not yet learned: Skills not yet learned: ***(AEPS: 0s, HELP: -s): List 3-5 CBA items representing skills/behaviors the child has not yet learned across all appropriate strands within this domain. If using the HELP, include only the skills scored as a +/- that appear within 3 months on either side of current level of development***.	
Percentage of Delay in this domain:	
Date CBA conducted	Signature of CBA Provider

Family training

Family training includes the design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas including cognitive processes and social interaction; providing families with information, skills and support related to enhancing the skill development of the child; and curriculum planning, including the planned interaction of personnel, materials, and time and space, that lead to achieving the goals in the child's IFSP/FSP.

The focus of early intervention is family training. Documentation in the child's file must support that family training is the core component of Early Intervention Services. Once trained the parent /legal guardian/caregiver should be able to perform the skills taught by the Early Interventionist.

The parent/legal guardian/caregiver must participate during scheduled visits. If three (3) consecutive family training visits are missed by the parent without notification before or after the scheduled visit, the Early Interventionist will send a letter to the parent/legal guardian/caregiver asking if they wish for the services to continue. If a reply is not received within ten (10) calendar days, the parent/legal guardian will be notified that services will end. The file would then be closed.

Who is eligible to receive Family training?

A child is eligible for Service Coordination/Family training with SCDDSN if he/she:

- Is three or four years of age, is DDSN eligible (including at-risk) and meets the following criterion;
  - Child demonstrates cognitive delay ≥ 25%; or
  - Child demonstrates social-emotional delay ≥ 25%; or
  - Child demonstrate a delay in one domain ≥ 40%; or
  - Child demonstrates ≥ 20% delay in *any* two domains;

OR

Is birth to three and has been determined eligible for SCDDSN services (high-risk).

Who is NOT eligible to receive Family Training?

A child is not eligible for Service Coordination/Family training when any of the following apply:

- Parent requests services to cease;
- Child no longer needs services;
- Child is over the age of three and is not eligible for DDSN services;
- Child is over the age of five (unless exception was granted by DDSN);
- Child resides in an institutional setting (i.e., habilitation center (formerly ICF/MR), nursing facility, a hospital within the Department of Mental Health or any other psychiatric hospital); or
- Child turns five years old unless justification is submitted and approved by DDSN Office of Children's Services staff.

Specific Roles and Responsibilities of Family Training Providers include:

1. Coordinating all activities through the IFSP/FSP process and in conjunction with the goals established on the child's IFSP/FSP;

2. Providing Family Training as identified on the plan. For example, if the plan indicates a need for FT 4 times per month for sixty minutes, and the EI is forced to cancel a family training visit, the visit must be made up (if the family agrees to or has requested the visit be made up) prior to the end of that month. Make up visits cannot be made up in the following month unless the canceled visit was in the last week of the month. All make up visits must be documented as such in service notes, regardless of whether or not the visit was made up with an additional visit another week or if the visit was made up incrementally over several visits throughout that month;

3. If a team decides that a child needs less than 2 hours per month of family training a Service Justification Form must be submitted to DDSN Children's Services staff for signature. If, for any reason, the parent has requested a decrease in family training that will not last more than 3 months the Service Justification Form (Attachment #2) is not needed. This request should be documented in the service notes;

4. In the unlikely event that a **team** indicates the need for 6 hours or more of Family Training per month the following information must be sent to the DDSN Children's Services staff; IFSP/FSP, Service justification form that documents why increase is being requested, data sheets and service notes, and any other documentation that supports the need for this level of service provision. This

5. information must be sent to Central Office within 15 days of completion of the plan for approval;

6. Offering an alternate EI to family if the EI is going to be out of the office for an extended period of time (more than a month). If the EI's leave of absence will be less than one month the EI should offer to make the visits up during that month. If family chooses to wait for their EI's return they must be explained that they will continue to receive service coordination and they must be made aware of whom the service coordinator will be in their EI's absence. (If the family chooses to the decline family training in the absence of the EI, a Service Justification Form must be completed and signed by the parent). The form must then be sent to DDSN Children's Service staff for review/approval;

7. Being available for all family members/caregivers including siblings and grandparents and:

    - Providing according to the frequency outlined in the IFSP/FSP as determined by the team.
    - Scheduling at times acceptable to the family and at locations and at locations within the child's Natural Environment.

8. Responsibilities include not attending doctor's appointments on a consistent basis. For example, an occasional visit to the physical therapist with the child to discuss and observe positioning techniques for use during family training is acceptable. It is not acceptable to attend doctor's appointments or therapy appointments on a weekly-basis. It is not sufficient to document that the parent requested that the EI attend. These visits should be justified in service notes and should include the reason for attending the visit and how the Early Interventionist participated in the visit while they were there;
9. Not to provide family training in a public preschool setting as Special Education teachers are trained to work with children with disabilities and their special needs. Visits to the preschool class for observational purposes (for plan and/or Assessment completion) on an occasional basis, no more than quarterly, is allowed. This does not apply to children in a typical childcare setting;
10. Teaching the parent developmental skills to enhance their child's development. Documentation in the child's file must support that parent training is a core component of this service;

11. Documenting all family training visits with the family/caregiver must be documented. The Family Training Summary sheets must be in duplicate form and one copy should be left for the family after each visit. (See Attachment #1 for sample Family Training Summary Sheet.)

12. Documentation must include:

    - Objectives for each visit, which address the child's needs across environments and are obtainable by the family.
    - Summary of activities.
    - The level of participation of parent/legal guardian/caregiver in the family training process. To state that the parent was present is not sufficient. The summary should include what instructions and/or strategies the EI gave the parent during the session to achieve a certain activity: For example, Mom gave Jane support at the base of her trunk while EI presented objects to encourage her to reach for and grasp the rattle.
    - Suggestions for family members/caregivers addressing the child's needs across all environments.
    - Follow-up activities to include upcoming appointments.
    - Date/time of next family training visit.
    - Early Interventionist and family member/caregiver signatures on family training summary sheets.
    - Time the Family training session begins and the time it ends.

13. Delivering services identified as needs on the plan as written. For example, if the plan indicates 60 minutes of family training, this must be provided apart from service coordination. It is not permissible to provide 45 minutes of family training and 15 minutes of service coordination to meet the required 60 minutes.

14. The transition process for 5 year olds should begin no later than 30 days prior to the child's 5th birthday. If after discussing the transition to Service Coordination the EI and family feel that the child should continue to receive family training, the EI must submit the Service Justification Form no later than 14 days after the meeting/phone call to DDSN Children's Services staff. The child and family should continue to receive special instruction until a determination is made by the Office of Children's Services staff.

SAMPLE
Family Training
Summary Sheet

Child's Name:_____ Date:_____
Who was present for visit?_____

Objectives/Strategies:
1._____

2._____

3._____

Summary:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Strategies the family can try this week _____
_____
_____

Service Coordination follow-up:
_____
_____

Follow-up by family:
_____
_____

Early Interventionist Signature:_____ Date:_____

Parent's Signature:_____ Date:_____

Time in:_____ Time out:_____

Our next visit is scheduled for:_____ Time:_____

Procedural Bulletin # 9
Attachment # 1

Service Justification Form

Child's Name:	Child's Age:
Early Interventionist's Name:	
Board/Agency:	Date:

- ❑ Special Instruction Frequency- The child will receive less than 2 hours per month of SI as determined by the TEAM (3-6 years).
- ❑ Child did not meet Special Instruction Indicators (3 or 4 year old)
- ❑ Child is 5 or is turning 5 years of age
- ❑ Declining of Services- The family does not wish to receive SI for an extended time frame (more than 3 months) for a specific reason OR the Special Instruction provider is unable to provider SI (for more than a month) and the family does not wish to have an alternate (0-6 years).

I do not wish to have an alternate Early Interventionist during my Early Interventionist's absence. Our family will continue to work on the outcomes identified on my child's IFSP/FSP during this time frame. I understand my family will continue to receive service coordination and I have been made aware of whom the service coordinator will be.

Parent's Signature_____

Early Interventionist's Signature_____

_____ Approved _____ Denied _____ More Information Needed _____

_____

Early Intervention Program Coordinator's Signature_____

Date_____

Parent's signature is NOT required for Special Instruction Frequency.

This form is not valid without approval from DDSN Central Office.

Procedural Bulletin #9

Attachment #2

Service Planning and Delivery

Early intervention services and supports are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development. Early intervention services are selected in collaboration with the family; provided by persons qualified to serve the child, and to the maximum extent appropriate to the needs of the child, provided in natural environments. Generally defined, natural environments are those the home and community settings in which children without special needs participate. Service providers must be flexible and offer families services in a variety of ways.

The "Requirements for the Planning and Delivery of Services and Supports" described in this Procedural Bulletin are meant to assist IFSP/FSP teams in considering a variety of factors as they make **individualized** decisions based on the resources, priorities, needs, interests and desired goals for individual children and families. This Procedural Bulletin incorporates early intervention requirements related to service planning and delivery, procedural instructions for implementing these requirements, and rationale for the service planning and delivery approaches expected of all providers. These requirements support DDSN's family-centered philosophy and implementation is expected to result in:

• the provision of supports and services that build on existing child and family strengths and interests.
• assistance to the family in achieving goals that make a meaningful difference in the life of their child and family.
• an increase in the child's participation in family and community activities, and
• support to the family in identifying learning opportunities and enhancing their child's development.

No two children or families have the same constellation of interests, needs, skills, challenges, resources, and desired goals even when they have similar evaluation results. Therefore, a review of any group of IFSP/FSPs is expected to show a wide range of supports and services, service frequencies, service providers, service locations, and community resources being used to address individual child and family goals.

These service planning and delivery requirements reflect expected practice throughout the time the child and family are receiving supports and services in early intervention, not just during initial planning and service delivery. Child and family needs, desired goals, informal supports and resources, and routines and activities change. Discussion with the parent must be continuous in order to plan and provide intervention that is in tune with the ever changing dynamics of the child and family.

The delivery of services and supports often involves caregivers other than the child's parent or immediate family. These caregivers may include grandparents or other extended family members and child care providers. Service providers are expected to consider other caregivers when implementing these requirements and involve them as appropriate and as described in the IFSP/FSP.

Requirements for the Planning and Delivery of Services and Supports:

Specifics about the Family-Provider Partnership

In partnering with families to address desired goals for their child and family, service providers join their developmental expertise with the family's expertise about their child and family in order to establish a shared understanding about how to best support the child's participation in family and community life. The focus should be on expanding the family's confidence and competence to identify opportunities to help the child learn during everyday activities.

Parents help identify other family members and caregivers in the child's life who may be able to assist in addressing the IFSP/FSP goals. The extent to which other caregivers are involved in addressing the IFSP/FSP goals will depend on a number of factors including, but not limited to; the extent to which the family would like to have these other caregivers involved, how much time the child spends with these other caregivers, and the willingness of these other caregivers to learn and apply strategies for increasing the child's learning opportunities and ability to participate in the everyday activities.

Specifics about Missed Appointments and Limited Caregiver Participation

Missed appointments and limited caregiver participation during contacts with service providers are cues that discussion is needed with the parent to determine if or why the goals or supports and services are not meeting the family's needs and what barriers might exist to his keeping scheduled appointments or being an active participant. Revisions to the IFSP/FSP may be needed to better align goals and supports and services with family priorities and daily activities and routines. It is important for Early Interventionist's and service providers to communicate effectively with the parent so that they understand why they are being contacted by the Early Interventionist and how early intervention services may be beneficial to their child and family. Likewise, service providers should involve the Early Interventionists when difficulties with parental participation are encountered.

When a parent is not engaging in Early Intervention services, the Early Interventionist should make numerous and varied attempts to contact the parent (e.g., phone calls, home

visits, mail, requesting assistance from the referral source, where appropriate, the child's physician, relatives, or other community resources) to explore with the parent how the early intervention program might better support their child and family. If unsuccessful in contacting the parent or resolving issues related to the parent's lack of participation, the Early Interventionist must call other team members if available to discuss the current situation and make a decision about whether or not there may be a legitimate cause for the cancellations (e.g., sudden change in health status requiring travel to doctors, or familial stressors, such as a death in the family).These factors should be considered when deciding whether to exit the child from the early intervention program.

Should the IFSP/FSP team recommend that the child be exited from the program, the Early Interventionist must send the parent a letter by mail that:

- states that attempts to involve the parent have been unsuccessful and briefly describes these attempts;
- requests that the parent contact the Service Coordinator within ten (10) calendar days, if he wishes to discuss continued involvement and the receipt of services, and
- informs the parent that he may contact the Agency at any time in the future about resuming participation in the early intervention program.

If the parent does not respond to this letter, the Early Interventionist must proceed according to the IFSP/FSP team's decision regarding whether to exit the child from the early intervention program. As appropriate, for children 3 to 5, the Early Interventionist must complete a closure form to exit the child from the early intervention program. If the child is birth to 3, the child's case should be closed only to the service of family training and must be sent back to the local DHEC office for closure to BabyNet.

Parent Declaration to Discontinue in the Program

If, at any time after enrollment in the early intervention program, the parent declares that they no longer want to participate, the Service Coordinator must send the parent a letter that restates the parent's decision, reviews what the early intervention program is and how it may be beneficial to the child and family, and inform the parent that he may contact the Agency at any time in the future about resuming participation in the early intervention program.

The Service Coordinator must communicate all decisions and actions related to parent participation and the child's enrollment to the members of the IFSP/FSP team. A copy of all written communication to the parent and notes of any other attempts to communicate with the parent must be filed in the Service Coordinator's record on the child.

Specifics about Goal Development

Service delivery options, including specific supports and services, service providers, and locations of service delivery are driven by the child and family's goals developed by the IFSP/FSP team. They are only determined after the desired child and family goals and potential learning opportunities have been identified. Goals are statements of change that the parent wants to see for his child and family as a result of their involvement in early intervention. As part of the IFSP/FSP process, goals are identified based on information gathered through the evaluation and assessment process.

This process includes conversations with the family to identify current activities and settings, potential child learning opportunities, successes and challenges, and areas where the family would like assistance. This process also includes a curriculum based assessment that addresses those activities, settings, opportunities, and areas (See Procedural Bulletin #8). After child and family goals have been identified, the IFSP/FSP team, which includes the family as an equal team member, determines the early intervention supports and services, including frequency, intensity, and duration, and the services necessary and appropriate to address the goals.

Individualized goals are provided in the context of everyday routines and activities, and are functional and integrated (i.e., goals are relevant for the family, focus on the child's participation in activities and settings that are important to the family, and focus on the whole child rather than discreet skills). Services are not goals; they are a means to achieving a desired goal. For example, "Johnny will receive physical therapy weekly" is not an goal. In contrast, "Johnny will sit independently while playing with toys" is appropriate wording for an goal statement. In developing desired goals, the IFSP/FSP team starts with activities and settings in which the family participates and identifies as important, as well as activities and settings the family would like to pursue.

Specifics about Supports and Services in Everyday Routines, Activities and Places

Consideration of child and family routines, activities and natural settings must occur throughout the early intervention process. The idea of supports and services in everyday routines, activities and places broadens the definition of natural environments to more than just a location for services. While location is important, it is only one element of quality services and supports. The elements of why the service is being provided, what the service is, who is providing it, when it is provided, and how it is being provided are the other essential characteristics.

Strategies to address the IFSP/FSP goals focus on learning opportunities that occur throughout the daily routines and activities of the child and family. These strategies

recognize the family as the primary influence of change in the child's development. The family helps the IFSP/FSP team and service providers understand these daily routines and activities. The service providers then assist the parent in recognizing and using existing opportunities as well as creating new learning opportunities that will help the child reach the desired goals. Service providers work with the parent to formulate adaptations to strategies and recommendations that will promote a child's participation in the activities and routines of their natural settings. Whenever possible, service providers use items already present in the child's environment when providing early intervention supports and services. They also assist the family to identify what they have in their own environment that can be used during daily routines and activities to accomplish the identified goals.

The IFSP/FSP team must consider multiple factors when identifying appropriate intervention supports and services to address IFSP/FSP child and family goals, including the expertise needed to support the family, abilities and interests of the child and family, needs expressed by the family, and family and community resources. Strategies must support the child's and family's ability to achieve the identified goals and their ability to function where they live, learn, and play.

Strategies for meeting goals incorporate activities other than the formal services provided by a particular discipline. Examples of informal activities may include library story time, playing in the park, and grocery shopping. These activities must be individualized to the child and relate to specific goals and activities spelled out in the child's plan. Family Training should not be provided at agency sponsored functions where services are delivered to children in group settings.

Specifics about Who Provides Services

The early intervention approach used in South Carolina allows for flexibility in how the specialized skills of early intervention providers are used in partnership with families in order to address the desired child and family goals identified by the IFSP/FSP team. This approach includes direct hands-on intervention, consultation with the family and other caregivers as they interact with the child, collaborating with other providers as needed, and an IFSP/FSP review process that allows changes to any of the above to occur as needed to meet current IFSP/FSP goals.

The IFSP/FSP team, which includes the parent, determines the appropriate early intervention supports and services needed to meet the desired goals. The team then identifies the expertise needed to support the parent to implement the IFSP/FSP strategies based on each child's and family's unique configuration of skills and interests, resources, needs, priorities, and desired goals. The match between the IFSP/FSP goals and strategies and the ability of the provider to support and assist the family in accomplishing those goals is the most important consideration in choosing an early intervention service provider to partner with that family.

When a need for more than one service provider is identified by the IFSP/FSP team, it is critical that all service providers collaborate with each other, the Service Coordinator and the parent to ensure that services are provided in an efficient and effective manner. Goals are to be integrated and discipline free, meaning not necessarily related to a single developmental domain or discipline, but reflective of the functional skills needed for participation in family and community life. The family's ability and desire to accommodate multiple providers should be considered when determining the frequency and intensity of contacts with providers.

Specifics about Where Supports and Services are Provided

Supports and services occur in the context of and must be integrated into the normal daily activities, routines and environments of each child and family. Supports and services fit into the family's life and build effectively on the resources and supports already in place.

For each child and family, the choice of location for supports and services is based on the activities associated with the desired goals on the IFSP/FSP. While the child's home or child care center may be an appropriate setting for supports and services for many activities, other natural settings such as a community center, a neighborhood park, the grocery store, etc. may be appropriate instead of, or in addition to, the home or child care center depending on the activity settings and learning opportunities the family identifies as important to them. The IFSP/FSP team should also consider providing services in multiple settings when appropriate for helping the child generalize new skills (e.g., mobility, behavior) in a variety of locations. The team should consider the following questions when discussing the specifics about where supports and services are provided:

1. Does the environment support the child's participation in the daily activities and routines of their family in community settings where children live, learn, and play?
2. Does the environment promote the parent's ability to model and reinforce behaviors in daily activities and caregiving between contacts with the provider?
3. Does the environment allow the child to experience a variety of sensory and physical stimuli that can enhance the child's responsiveness to the service?
4. Does the environment foster the use and development of natural supports in the family's social and cultural network and promote the family's integration into community life? and
5. Does the environment support the acquisition of skills in the child's and family's daily routines?

Specifics about Frequency and Intensity of Supports and Services

Early intervention supports and services are focused on enhancing the child's ability to participate in family and community life and supporting the family's ability to enhance their child's development. Frequency and intensity means the number of days or sessions that a service will be provided and the length of time the service is provided during each session.

Two broad, critical questions for the IFSP/FSP teams to ask in determining the frequency and intensity of supports and services needed to meet the IFSP/FSP goals are:

1. How often will the child's intervention likely need to be changed? and
2. How often does the family need support to feel confident in using intervention strategies?

In determining the answer to each of these two broad questions, the IFSP/FSP team is expected to consider the following factors:

How often will the child's intervention likely need to be changed?

• Is the relationship between the child and family and the provider new (e.g., because they have just begun Infant-Toddler Program services or there has been a change in providers) or well established? If the family is just beginning services from their initial Individualized Family Service Plan, there may be more frequent changes in strategies as the Infant-Toddler Program provider continues learning about the activity settings, routines, and how the child responds to proposed strategies.

• Will the strategies used to address the goals need to be modified frequently or will the same strategies be used for a long period of time?

• Is attainment of a goal especially urgent and able to be resolved quickly with intensive intervention (e.g., new referral of a child with non-organic failure-to-thrive, which needs quick resolution, a child's behavior is prohibiting the family from finding a child care provider to accept the child)?

• Are there a large number or a wide variety of strategies involved in addressing the desired goals or are there relatively few or more similar strategies?

• Is the child progressing at the expected rate in meeting identified goals?

How often does the family need support to feel confident in using intervention strategies?

• Are the services provided at a frequency and intensity that matches the family's need for timely, additional guidance at each contact?

• Do the goals identified require a high level of specialized skill or are they more easily implemented with minimal guidance and instruction? When a higher level of skill is needed to address goals, there may be a need for an increased frequency or intensity of services and supports for a period of time while the family becomes comfortable in implementing the strategies.

• Are the goals or strategies new for the child and family? The need to increase frequency or intensity of services may be evident when a child enters a new developmental phase and more frequent guidance is needed by the family.

• Will the service provider be working with other caregivers in addition to the family in addressing goals? If the service provider will be working with a variety of caregivers, more frequent services may be needed for a period of time. This extra time will allow the service provider to learn more about the child's daily activities and routines with these other caregivers and to teach them various strategies and skills to address desired goals.

• Is the parent's ability to participate in implementing suggested activities affected by his or her own cognitive or emotional issues? If so, the IFSP/FSP team will need to consider how other informal and formal community resources and supports, other caregivers, and early intervention services can be combined to best address the full constellation of child and family needs. However, more frequent early intervention services are not a substitute for an active parent-provider partnership that includes involvement by the parent in each early intervention session.

• Does the child need intensive, one-on-one support to participate in his environment? Under these circumstances, there also may be a need for an increase in support to the family in addressing the IFSP/FSP goals.

It is expected that the frequency and intensity of Early Intervention supports and services will change over time for an individual child and family, sometimes increasing and sometimes decreasing, as the variety of factors outlined above change. As with other aspects of service delivery, only the IFSP/FSP team can make decisions about the frequency and intensity of service delivery. This decision cannot be made by individual providers. Third party payers, such as Medicaid and insurance companies, may authorize or reimburse service providers for more visits or place limitations on the frequency and intensity of services and may specify the number of contacts by a service provider. See Procedural Bulletin #9 for specifics on family training delivery.

Family Service Plan (FSP) Development

Please Note: For information regarding the completion of the IFSP document, please refer to the Babynet Policy and Procedure Manual.

Roles and Responsibilities related to Plan Development:

Planning by the Early Interventionist is an ongoing process from the initial referral to Early Intervention Services through transition or closure. For this reason, planning **will** overlap with all other early intervention activities. Planning includes activities leading to a comprehensive FSP that identifies and documents the needs and goals and how these needs and goals will be addressed (See attached FSP). It also captures the desires and wishes of the parent/legal guardian and identifies and documents the services and supports to address them. If the parent/ legal guardian requests the assistance of an independent facilitator, an important role of the Early Interventionist as the plan manager, is the coordination and communication of information between the parent/legal guardian, the independent facilitator, and persons who have a meaningful role in the life of the child. The FSP must be developed by a team composed of the family/caregiver, the Early Interventionist, interested friends and professionals who know the child and family. The team meets at locations and times convenient for the family. The family has the right to approve/disapprove the composition of the team.

Specific Roles and Responsibilities of Early Interventionists related to the FSP:

Initial FSP:

1. If a referral is received on a child over the age of three, an FSP must be completed by the Early Interventionist and parent/legal guardian within 30 calendar days of the date of provider choice being offered to the family during the screening process.

2. For a child who is Babynet eligible and will continue to receive services from DDSN, an FSP must be completed prior to the child's third birthday. The FSP must not be completed more than two weeks prior to the child's third birthday and the effective date of the FSP will be the date of their third birthday. If the FSP must be completed more than two weeks prior to the child's 3rd birthday the Early Interventionist must consult with their supervisor and document the circumstances in their service notes.

Choice of Service Coordination Provider:

The parent must be given a choice of providers of services and supports. This choice must be inclusive of all potential providers. This is important, particularly when the child resides temporarily in a county that is not his/her Home County such as an out-of-home placement. If there is only one potential provider, the parent/legal guardian must be informed. The choice of provider must be offered and documented at time of intake and at least annually thereafter. This offer of choice must be documented on the Acknowledgement of SC/EI Provider Choice. See Policy Bulletin 7, Attachment 1.

Facilitation of the FSP:

1. Children 3-6 years of age that are eligible for DDSN services (i.e., have MR, RD, Autism, or are served in an MR time limited category) may choose to utilize an independent facilitator to plan for their future. If the child's eligibility is established after the initial FSP has been completed the family will be given information about facilitation and offered a choice of a facilitated plan prior to the next plan date.

    a. The parent must be offered facilitation, a choice of facilitators, and a choice of date, time, and location of the FSP meeting.

    b. The Early Interventionist must assist the parent/legal guardian with identification of a circle of support consistent with the child's/families needs and desires.

2. Facilitating the FSP, including discussions of functional developmental concerns, the child's present level of development, child and family strengths and needs;

The Early Interventionist is responsible for:

1. Working with the parent and other FSP team members to identify specific functional goals for the child and family and how to incorporate these goals into daily routines, activities and places;

2. Identifying with the parent natural environments and supports existing in the community that are appropriate for the child and family;

3. Working with the parent and other FSP team members to determine the level of assistance needed for the child to function successfully and achieve identified goals in such environments;

4. Working with the parent to select service providers once goals are identified;

5. Explaining the content of the FSP so that the parent fully understands the content and implications;

6. Determining with the parent the specific nature of assistance the Service Coordinator will provide to support and assist the family in implementing and monitoring the FSP;

7. Obtaining required signatures and assuring that the parent and other team members have a copy of the FSP within 10 days of completion;

8. Completing reviews of the Plan with the parent and other FSP team members and modifying the FSP as appropriate;

9. Actively monitoring services for quality and recommended practices, including being present for some services, talking with the parent as well as service providers regarding the provision of services, discussing progress made toward goals, identifying any new concerns, reviewing service delivery documentation, etc.;

10. Arranging new evaluations by other providers, as appropriate;

11. Gathering the parent's input on system issues and goals, service provision and parent's satisfaction with the supports and services they are receiving;

12. Identifying with the parent appropriate FSP team members based on child and family information.

Transfers:

If a case is transferred to another Early Intervention provider then either a new plan must be completed or the current plan must be updated within 14 days of the transfer.

Family Service Plan Reviews:

1. Within six-months of the annual FSP date the Early Interventionist must convene a six-month review of the FSP (e.g., If the FSP was completed on 7/1/06 the six-month review is due no later than 1/1/07. If the six-month review was completed on 1/2/07 it was late). All developmental Goals will be assessed at the six-month review of the FSP. The appropriate Goal Attainment score should be documented on each outcome page of the FSP during the review.

2. A new FSP must be completed with the family and other team members who play a significant role in the child's life. The annual FSP is due no more than six months from the six-month review date of the FSP. For example, if a child's annual plan date is December 20, 2005 and their six-month review is due on June 20, 2006, but the six-month review was completed on June 1, 2006, the next annual plan is due before December 1, 2006.

A copy must be provided to the parent/legal guardian within 10 days and a copy placed in file.

The Family Service Plan must contain:

1. Identifying information;

2. Current health and developmental status;

3. Child assessment and evaluation results;

4. Family and child strengths, including family preferences and choices;

5. Recommendations for services to be provided to meet the identified needs of the child and family;

6. Outline for implementation of services recommended, including the frequency/duration of those services/activities (with indicator of source of payment or method of funding);

7. Child interventions as determined by the family and team;

8. Strategies which promote family/caregiver as the primary teacher for the child;

9. Goals as identified by the team;

10. Plans for follow-up;

11. Parent, Early Interventionists and other team member's signatures;

12. Support for Home and Community Based Waiver services where applicable; and

13. Documentation of the frequency and duration of family training visits.

More detailed information regarding FSP instructions can be found in FSP Completion Guidance-Attachment #2.

Please Note: The attached DDSN FSP form must be used for children 3 to 5 years old. It cannot be modified or changed at any time by any provider.

SOUTH CAROLINA Department OF Disabilities AND Special Needs

_____'s

Family Service Plan

Date of FSP:_____

SECTION 1: CHILD INFORMATION

Child's Name:_____ Date of Birth:_____
first/middle/last

Home Address:_____

City:_____ State: SC Zip Code:_____

Gender: (circle one) M F Name of School District and/or Head Start_____

Social Security #_____ Medicaid #: _____

Private Insurance Company Name and Policy #_____

SECTION 2: GENERAL CONTACT INFORMATION

Parent:_____ Relationship to Child:_____
first/last

Home Address:_____

Directions to the home: _____
_____
_____

Phone: Home _____ Work:_____ Other:_____

E-mail: _____

Primary Language/Mode of Communication:_____ Interpreter Needed: (circle one) Y N

Other Contact information

Name:_____ Relationship to Child:_____

Phone:_____ Other phone: _____

SECTION 3: SERVICE COORDINATION PROVIDER

Service Coordinator Name_____

Service Coordination Provider Agency _____phone_____

Other phone _____ Email address_____

SECTION 4: FSP TRACKING		
FSP Meeting Date: _____	**Projected FSP Team Meeting Dates:** 6-Month Review:_____ Annual Evaluation:_____	
Date FSP mailed to: Family_____	Other FSP Team Members _____	Primary Health Care Provider _____

SECTION 5A: FAMILY'S VIEW OF CHILD'S CURRENT HEALTH

Primary Healthcare Provider:

Does your child have a primary health care provider? ☐ No ☐ Yes

If not, there should be a linkage to a provider (reflect as a service coordination goal).

Primary Health Care Provider:_____ **Phone:** _____

Address: _____ **Fax:** _____

General Health:

Is there anything about your child's current mental or physical health, including diagnosis(s) that the team should know about to better plan and provide services to you and your family?

Medications Routinely Taken	Reason for Medication

Does your child have any allergies? ☐ no ☐ yes If yes, please list:

Does your child use any specialized medical equipment, i.e., oxygen, pulse ox, g-tube, vent dependent
☐ no ☐ yes If yes, please list:

Vision: Has your child's vision been tested? ☐ no ☐ yes
If yes, Date:_____ Physician's Name:_____

Results of vision evaluation if applicable:

Other comments by family or FSP Team:

Hearing: Has your child's hearing been tested? ☐ no ☐ yes
If yes, Date:_____ Physician's Name

Results of hearing evaluation if applicable:

Other comments by family or FSP Team:

Nutrition: Are there any concerns about your child's eating, general nutrition, or growth? ☐ no ☐ yes

☐ Special Formula (specify_____)

☐G-tube feedings (Bolus and/or continuous pump)

☐ Other, please list (ex., transitioning from G-tube to oral feeding):_____
If yes to any conditions listed above please describe:

Other comments by family or FSP Team:

Oral Health Has your child's mouth and/or teeth been checked? ☐ no ☐ yes
How long did your child use the following? ☐ Bottle _____ mos/yrs ☐ Pacifier _____ mos/yrs
Has your child been on any of the following medications for extended periods of time (3 months or more)?
☐ Seizure medications ☐ Prescription Antibiotics
If yes to any conditions listed above please describe:

Other comments by family or FSP Team:

SECTION 5B: HEALTH CARE PROVIDERS

Provider's Name_____ Specialty_____
Address_____Phone_____

Provider's Name_____ Specialty_____
Address_____Phone_____

Provider's Name_____ Specialty_____
Address_____Phone_____

Provider's Name_____ Specialty_____
Address_____Phone_____

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Provider's Name_____ Specialty_____
Address_____Phone_____

Provider's Name_____ Specialty_____
Address_____Phone_____

Provider's Name_____ Specialty_____
Address_____Phone_____

SECTION 6A: FAMILY VIEW OF CHILD'S PRESENT LEVEL OF FUNCTION

Social/Emotional: Are your child's **social skills** or **emotional development** of concern to you? ☐ no ☐ yes
Check all the activities below the child has mastered

- ☐ Shows no interest in peers
- ☐ Shows anxiety when separated from caregiver
- ☐ Does not imitate adults or playmates
- ☐ Objects to major changes in routines

Other comments (if needed):

Communication: Are your child's **communication skills** of concern to you? ☐ no ☐ yes
Check all the activities below the child has mastered

- ☐ Does not point to objects
- ☐ Babbles, no words
- ☐ Does not use single word/phrases
- ☐ Does not speak in sentences
- ☐ Will not indicate wants/needs
- ☐ Does not understand physical relationships ("on", "in")
- ☐ Does not recognize/identify most common objects and pictures

Other comments (if needed):

Cognitive: Are your child's **thinking or problem-solving skills** of concern to you? ☐ no ☐ yes
Check all the activities below the child has mastered

- ☐ Does not play make-believe with dolls, animals and people
- ☐ Cannot complete 3-4 piece puzzle
- ☐ Will not follow one or two step commands
- ☐ Will not sort objects by size and/or shape

Other comments (if needed):

Self-help skills: Are your child's **self-help skills** of concern to you? ☐ no ☐ yes
Check all the activities below the child has mastered

- ☐ Will not attempt to remove clothing
- ☐ Does not attempt to put clothes on
- ☐ Does not show any interest in potty training
- ☐ Will not attempt to feed him or her self
- ☐ Does not finger feed
- ☐ Will not attempt to use a spoon or fork

Other comments (if needed):

Motor skills: Is there anything about how your child **moves** that is a concern to you? ☐ no ☐ yes
Check all the activities below the child has mastered

- ☐ Cannot sit independently
- ☐ Cannot pull to stand
- ☐ Does not cruise furniture
- ☐ Does not walk independently
- ☐ Will not imitate vertical, horizontal, circular strokes with a pencil or crayon
- ☐ Cannot screw and/or unscrew lids, nuts and bolts
- ☐ Will not / cannot turn the pages of a book

Other comments (if needed):

SECTION 6B: ASSESSMENT OF CHILD'S PRESENT LEVEL OF FUNCTION	
Date of FSP:	**Child's Name:**
Date of CBA completion:	**CBA Tool:** ☐ **AEPS** ☐ **HELP** ☐ **Carolina Curriculum**
Name of CBA Provider *please print*:	
Overall strengths of child, successful strategies used in the assessment, and factors that may have affected assessment process	
CBA Results for Social –Emotional Domain	
Social-emotional skills child currently demonstrates:	
Skills newly learned/emerging:	
Skills not yet learned:	
Percentage of Delay in this domain:	

CBA Results for Cognitive Domain
Cognitive skills child currently demonstrates:
Skills newly learned/emerging:
Skills not yet learned:
Percentage of Delay in this domain:
CBA Results for Communication Domain
Communication skills child currently demonstrates:
Skills newly learned/emerging:
Skills not yet learned:
Percentage of Delay in this domain:

CBA Results for Self-Help/Adaptive Domain	
Self-help/adaptive skills child currently demonstrates:	
Skills newly learned/emerging:	
Skills not yet learned:	
Percentage of Delay in this domain:	
CBA Results for Motor Domain	
Gross motor skills child currently demonstrates:	Fine motor skills child currently demonstrates:
Gross motor skills newly learned/emerging:	Fine motor skills newly learned/emerging:
Gross motor skills not yet learned:	Fine motor skills not yet learned:
Percentage of Delay in this domain:	Percentage of Delay in this domain:

SECTION 6C: OTHER TEAM MEMBERS' VIEW OF CHILD'S PRESENT LEVEL OF FUNCTION IF THERE ARE NO OTHER TEAM MEMBERS THIS SECTION MAY BE LEFT BLANK
Social-emotional skills:
Cognitive skills:
Communication skills:
Self-help skills:
Motor skills:

SECTION 7: FAMILY'S RESOURCES, PRIORITIES, AND CONCERNS (VOLUNTARY BY FAMILY)	
☐ **Family declined family assessment of resources, priorities, and concerns** **Parent's initials: _____** ☐ **Date Family Assessment completed:**	
I have questions about or want help for my child in the following areas (check all that apply): 1. ___Moving around (crawling, scooting, rolling, walking) 2. ___Ability to maintain positions for play 3. ___Talking and listening 4. ___Thinking, learning, playing with toys 5. ___Feeding, eating, nutrition 6. ___Having fun with other children; getting along 7. ___Behaviors/appropriate interactions 8. ___Expresses feelings 9. ___Toileting; getting dressed; bedtime; other daily routines 10. ___Helping my child calm down, quiet down 11. ___Pain or discomfort 12. ___Special health care needs Other: _____	Family's remarks regarding concerns identified about their child (including any not listed):
I would like to share the following concerns and priorities for myself, other family members, or my child (check all that apply): 1. ___Learning more about how to help my child grow and develop 2. ___Finding or working with doctors or other specialists 3. ___Learning how different services work or how they could work better for my family 4. ___Planning for the future; what to expect 5. ___Parenting skills 6. ___People who can help me at home or care for my child so I/we can have a break; respite 7. ___Child care 8. ___Housing, clothing, jobs, food, or telephone 9. ___Information on my child's special needs, and what it means 10. ___Ideas for brothers, sisters, friends, extended family 11. ___Money for extra costs of my child's special needs 12. ___Linking with a parent network to meet other families or share information (☐ P2P ☐ PTIC ☐ CRS) Other: _____	Family's remarks regarding identified priorities of the family (including any not listed):
Strengths, resources that our family has to meet our child's needs (**must** include statement of family's home and community routines and activities):	

SECTION 8: ELIGIBILITY

DDSN Eligibility Category

☐ Mental Retardation/Related Disability ☐ High-Risk ☐ Autism
☐ HASCI ☐ At-Risk Expiration date:_____
☐ DDSN Eligibility pending ☐ MR- Time Limited Expiration date:_____

SECTION 9: OTHER SERVICES

Other Services include, but are not limited to, respite, PCA, MR/RD Waiver service, etc…

Resource/Service	Provider Name	Amount/Frequency and Intensity	Funding Source

SECTION 10: CHILD/FAMILY CENTERED GOAL

A goal is a statement of change the family would like to see happen for themselves and/or their child.

Goal #:	Date of Goal:	Target Date:

GOAL: What knowledge, skill, behavior or would we like to learn or see learned by our child?

MEASURING PROGRESS: What difference will this make for our child and/or family? How will we know when the goal has been met? List specific skills from the CBA that are components of this goal

NATURAL SUPPORTS: Ideas, strategies, and people needed to achieve this goal within the child's everyday routines, activities, and places

ADAPTATIONS AND/OR MODIFICATIONS: Special accommodations/adaptations/equipment that can help make this happen (Assistive Technology).

SERVICES TO CONSIDER: What services are needed in order to achieve this goal in everyday routines, activities, and places?

Date Reviewed: ☐ **Change Review** ☐ **6-month Review** ☐ **Annual Evaluation**

☐ 1-Situation changed, no longer a need ☐ 2-Situation changed, still a need ☐ 3-Intervention started, still a need ☐ 4-Goal partially attained or accomplished but not to team's satisfaction	☐ 5-Goal attained or accomplished but not to team's satisfaction ☐ 6- Goal mostly attained or accomplished to team's satisfaction ☐ 7- Goal attained or accomplished to the team's satisfaction

Comments:

Date Reviewed: ☐ **Change Review** ☐ **6-month Review** ☐ **Annual Evaluation**

☐ 1-Situation changed, no longer a need ☐ 2-Situation changed, still a need ☐ 3-Intervention started, still a need ☐ 4-Goal partially attained or accomplished but not to team's satisfaction	☐ 5-Goal attained or accomplished but not to team's satisfaction ☐ 6- Goal mostly attained or accomplished to team's satisfaction ☐ 7- Goal attained or accomplished to the team's satisfaction

Comments:

SECTION 11: SERVICE COORDINATION GOALS				
#	Family-Identified Need (Family Assessment or as needs arise)	Action Taken (Teaming, Advocacy, Linkages)	Date Initiated	Date Completed

SECTION 12: SIGNATURE SECTION FOR FSP	
Type of FSP ☐ **Initial FSP** ☐ **Change Review** ☐ **Six-Month Review** ☐ **Annual Review**	
Signature of Parent(s):	**Date:**
For a child aging out of BabyNet the Initial FSP effective date will be the child's third birthday. **FSP Effective Date:**_____	
FSP meeting Notes:	

FSP Team Members

Method Codes: A = Attended, S = Speakerphone, E = Written Evaluation Only

Signature/Name	**Role**	**Agency** (if applicable)	**Method Code**	**Date**
	Service Coordinator			

SECTION 13: MEDICAL AND THERAPY UPDATES	
Date	**Brief summary of appointment, including date and provider**

SC Department of Disabilities & Special Needs
Family Service Plan (FSP)

Instructions for Completion

The Family Service Plan (FSP) describes how the Early Intervention System will assist each family in helping their young child with a disability or developmental delay to grow and develop.

The information that follows is intended to assist Service Coordinators, Service Providers, families, and all others involved in the consideration of the content and completion of the FSP form to ensure that all agreed upon Goals and services are documented for each eligible child and family.

The FSP form is divided into several sections. Each section has specific instructions for its completion.

Section 1: Child Information

Child's name: Record the child's given or legal name.

Date Of Birth: Record the month, day and year of the child's birth.

Home Address: Record the street address, city a zip code where the child is residing. Note that the street address for the child may be different from the address of the parent.

Gender: Identify the child as male or female

Name of School District: This will be the school district the child resides in at the time of the FSP meeting.

Social Security #: Record the Social Security number of the child. If the child does not have Social Security # at the time of the plan leave blank and complete once the number has been given.

Medicaid #: Record the child's South Carolina State Medicaid number, if applicable.

Private Insurance Company Name and Policy: Record the child's primary insurance's name and policy number, if applicable.

Section 2: General Contact Information

Parent: List the name of the individual who will be the primary contact for this child. The parent should be the individual who has physical custody of the child.

Relationship to Child: Indicate the relationship of the parent to the child. Use one of the following choices.

Father	Grandmother	Legal Guardian
Mother	Grandfather	Step Father
Aunt	DSS Caseworker	Step Mother
Uncle	Foster Father	Foster Mother

In the case where parents live separately, even though both parents may share legal custody, the name of the parent who has physical custody of the child is recorded first and in the other contact information, list the other parent. If both parents have legal custody, they both must receive written prior notice/meeting notification and both are decision- makers in the FSP process.

Home Address: Complete this only if different from that of the child.

Directions to the Home: Record the directions to the child's home or place of residence.

Phone: Record the Parents' home phone number, work phone number (if applicable), and other could be used for cell phone or any other number the Parent would like to be included. A section for email was given in the event that the family has email and wishes to communicate via email.

Primary Language/Mode of Communication: Ask the family what their primary language/mode of communication is and record in this section. If an Interpreter is needed in order to communicate with the family, indicate this by circling Y (yes) or N (no).

Other Contact Information: Use this section to list any key contact individuals for the child.

Relationship to Child: Indicate the relationship to the child.

Phone: Record the other contact's phone number.

Section 3: Service Coordination Provider

Service Coordinator/Family Training provider: Record the name and contact information of the individual who has been assigned as the family's ongoing Service Coordinator/Family Training Provider.

Service Coordination Provider Agency/Phone/E-mail: Record the primary Service Coordinator's Agency name, phone number, and email if applicable.

Section 4: FSP Tracking

FSP Date: Record the date (m/d/y) that the FSP team met and the FSP document was completed. If it takes more that one meeting to complete the FSP, record the date of the meeting at which the FSP was signed by the family.

Projected Dates:
6-month review: Must take place no more than 6-months after the FSP meeting. The date will be projected and recorded. For example, if the FSP date is 6/5/05 the six-month review must be completed no later than 12/5/05.

Annual FSP: Must be completed within 365 days of the previous initial or annual FSP. The date will be will projected 364 days from the date of the current FSP meeting. For example, if the FSP meeting is taking place on 6/5/05 the annual FSP must be completed by 6/4/06. The annual FSP must occur in a timely manner in order for new payment authorizations to be completed for service providers, if applicable.

If the 6-month review is held two weeks early this will change the annual FSP review date. For example, the FSP date is 6/15/05 and the 6-month is completed on 6/1/05 the annual FSP is due on 5/31/06.

Date mailed to the: Parent, FSP Team Members, and Medical Home (with consent). Record the date the FSP was mailed or delivered to these individual.

Section 5A: Family's View of Child's Current Health Status

This section is intended to gather information regarding the current health status of the child. The health status of a child can be important information for the FSP team to have in preparation for the delivery of services. This section should be used to justify any MR/RD or HASCI Waiver services when applicable. For example, if the child is in need of Nursing section 5A should clearly document any conditions that would justify the needed service.

Primary Healthcare Provider: Does the child have a primary health care provider? Indicate Yes or No by checking the appropriate box. If the child does not have a primary health care provider, the service coordinator should assist the family in locating a primary health care provider and indicate this as a Service Coordination Goal on the FSP.

If the child has a Primary Healthcare Provider, indicate the name, phone number, address, and fax number.

General Health: Ask the parent if there is anything about their child's current health that the TEAM should know about to better plan and provide services to their family.

Current Medications: Record any medications the child is currently receiving and the reason the child is taking them.

Allergies: Inquire if the child has any allergies that the parent knows of. If so, list the reaction the child has as a result of the allergy.

Specialized Medical Equipment: List any specialized medical equipment the child uses. Examples include, g-tube, oxygen, vent, AFO's, Pulse Ox, etc.

Vision: Inquire if the child has had a vision exam recently and indicate Yes or No with a check mark. If the parent or any FSP TEAM members have any other comments, record them in the other team member's comments section. If the child has not had a Vision Exam in the last year use the Curriculum Based Assessment to keep this section up to date.

Hearing: Inquire if the child has had a hearing exam recently and indicate Yes or No with a check mark. If the parent or any FSP TEAM members have any other comments record them in the other team members section. If the child has not had a Hearing Evaluation in the last year use the Curriculum Based Assessment to keep this section up to date.

Nutrition: Inquire if the parent has any concerns about their child's eating, general nutrition, or growth. Indicate their answer by checking either Yes or No. Check any of the following, if the parent, indicates a concern. If the Parent or any other FSP TEAM members has any other concerns or comments indicate this in the other comments section.

Oral Health: Inquire if the child has seen a dentist. If so, record the date and the name of the dentist seen. Inquire how long the child was on a bottle and pacifier. Ask the parent if the child has been on any Seizure medication or antibiotics for an extended period of time (3 months). If the parent has answer yes to any of the above ask them to describe. **If the child has been on the bottle/pacifier or as had to take seizure medications and antibiotic for extended periods of time it may be appropriate to discuss the child seeing a Pediatric Dentist.**

SECTION 5B: Health Care Providers

Inquire if the child currently sees any medical specialists. List the name, specialty, address, and phone number.

Section 6A: Family's View of Child's Present Level of Function

This family's view section must be completed prior to the FSP meeting and reviewed and expanded by the full FSP TEAM at the FSP meeting. The family should be assisted to complete this section in order to develop, in their own words, a statement of their child's skills in all development levels. Each section includes skills that the child may or may not currently display. These developmental milestones should prompt conversation between the family and EI. Check all the items that the child <u>can</u> do at this time and list any others in the other comments by parent section. In crafting the language for this

section, it is important to be positive, talking about the skills that the child has and how these are applied in daily living situations. Document any emerging skills and interests, skill quality and intent. Comments related to quality and intentions of movement are helpful once the basic skills are defined and discussed. Age equivalents, percent of delay, or standard deviations should not be included in this section of the FSP. The developmental domains are: cognition (thinking skills), language and communication, physical (fine and gross motor skills), adaptive skills such as eating, dressing and bathing, and social/emotional skills

Section 6B: Assessment of Child's Present Level of Function (Curriculum-Based Assessment Report)
Each child will receive a curriculum-based assessment across all domains of development prior to the Initial and each Annual FSP.

FSP Date: Complete at the FSP Team Meeting.

Child's Name: Record child's first and last name on each page of Section 6B

Date of CBA completion: Record the date the CBA was completed.

CBA Tool: Indicate which CBA tool was utilized to assess the child's present level of function:

AEPS: Assessment, Evaluation, and Programming System
HELP: Hawaii Early Learning Profile
Carolina Curriculum

CBA Provider: Printed or typed name and agency of CBA provider

Overall strengths, assessment strategies, and factors affecting the assessment process: provide a brief narrative of the assessment situation, and participants. Include any unique strengths the child demonstrated in performing assessment items, strategies found to be successful with the child in conducting the CBA, and any factors that may have affected the child's performance during the assessment process.

CBA Results
All domains must be assessed and reported for development of the Initial and Annual FSP.
For each domain of development, the following must be reported:
Skills the child currently demonstrates: ***(AEPS: 2s, HELP: +s, Carolina Curriculum: +s):*** List 3-5 CBA items representing the highest level of development across all appropriate strands within this domain

Skills newly learned or emerging: ***(AEPS: 1s, HELP: +/-s, Carolina Curriculum +/-s)***: List 3-5 CBA items representing newly learned skills that appear within 3 months on either side of current level of development, across all appropriate strands within this domain

Skills not yet learned: ***(AEPS: 0s, HELP: -s Carolina Curriculum: -s)***: List 3-5 CBA items representing skills/behaviors the child has not yet learned, within 3 months on either side of the current level of development, across all appropriate strands within this domain

Percentage of Delay: Record the percentage of delay as measured by the CBA for each domain of development

Section 6C: Other Team Members' View of Child's Present Level of Function:

Record discussion of the FSP Team about the CBA findings.

Section 7: Summary of Family's Resources, Priorities, and Concerns to enhance the development of their child

At the top of the page indicate whether or not the family gave their consent to participate in the family assessment. If the family does not consent to participate indicate that at the top of the page with an initial from the family and leave the remainder of the page blank.

If the family gives consent to complete the family assessment review the examples of questions, concerns and priorities and check all that are appropriate. On the right side of the page elaborate (and include any not listed) on any of the items the family voiced concerns about. On the bottom right side of the page record any strengths and/or resources the family currently has to meet their child's/family's needs.

Section 8: Eligibility

Check the appropriate eligibility category at the time the FSP is completed.

Section 9: Other Services

This section provides the opportunity for the FSP Team to review any other services identified as necessary to meet the child and family goals. Any service that a child is receiving must be documented in this section (i.e. MR/RD Waiver Services, Family Training, Housing, Food Stamps, Clothing, CLTC (PCA), etc…).

Resources/Service: Record the name of the service here (All MR/RD and HASCI Waiver services must be listed per Waiver Manual requirements).

Provider: Write in the name of the person or agency that will provide this service.

Amount/Frequency/Intensity: Include how often and how much of each service being provided.

Section 10: Child/Family Goals

This section provides the format for defining individual Goals related to the child and family's needs. It includes the specific objectives and strategies for addressing and achieving the Goal. If the family completes the resources, priorities ad concerns section of the FSP the FSP Team needs to consider this information when developing Goals.

The entire FSP Team participates in completing this step of the FSP process. All team members should come to the FSP meeting with an idea of the family's routines, concerns, and priorities so they are prepared to offer suggested strategies to the family. Unless the family wishes otherwise, the team should address each of the family's priorities and concerns with a Goal. The service providers should not create any Goals that are not directly related to a family priority or concern. Goals do not come from the evaluation and assessment process but from family priorities and concerns.

There will only be one Goal per page.

Goal #: Each Goal will be numbered consecutively.

Date of Goal: Record the date the Goal was developed.

Target Date: The date in which the FSP Team feels the Goal may be achieved. The Goal cannot exceed 365 days.

Goal Statement: What skill, Behavior or Knowledge would we like to see accomplished? The "we" in this statement refers to the family. Describe what the family wants the change to look like. The team may need to talk about the desired change so they can develop a statement that includes enough detail that the family and the FSP team will know when the Goal has been achieved. The Goal should directly relate to a family priority or concern.

****Example Goal Statement (child development):**
"Katie will step over the thresholds in her house without help or falling each time she tries so she can go from room to room safely."

Other Example Goals statements:
1. Katie will express feelings, needs and opinions with age appropriate behavior each time she interacts with adults and peers.
2. Katie will begin to develop the ability to focus and complete a variety of tasks, activities, projects, and experiences.

3. Katie will begin to develop the ability to recognize and solve problems through active exploration, including trial and error and interactions and discussions with peers and adults.
4. Katie will develop strength, dexterity and control needed to use tools and materials such as scissors, crayons, play dough, and manipulate other objects.
5. Katie will develop an awareness of her body, control and balance and walking, climbing, running, jumping, hopping, skipping, marching, galloping, riding a tricycle, and creative movement.
6. Katie will show creativity and imagination in using materials and in assuming different roles in pretend play situations.
7. Katie will develop hand-eye coordination in building with blocks, putting together puzzles, reproducing shapes and patterns, stringing beads, and using scissors.

How will we know when the Goal has been met and what difference or change will occur for the family once this Goal is achieved? The focus of this Goal statement is to clearly state how we will know the Goal has been attained and describe what difference or change for the family will occur once this Goal is achieved.

Natural Supports: Ideas and Strategies to achieve this Goal within the family's home and community routines and activities/child's everyday routines, activities, and places (Natural Supports): Strategies refer to the methods that the service providers and the family will use to address the identified child/family Goals. In the case of child development Goals, strategies include the ways service providers will support the caregivers' ability to use intervention strategies or maximize natural learning opportunities for their child. The person who will be implementing intervention should be obvious from reading the strategy, and unless determined inappropriate should include the caregiver(s) as the primary implementers. The team should brainstorm strategies to be considered for addressing the Goal within the child and family's daily routines and activities. Next, the team should choose strategies that will best address the Goal within the context of the family's life. Strategies should include the routine in which they will be implemented.

****Example Strategies (child development):**
PT will give strategies to Katie's mother and father. These include teaching Katie - how to anticipate that she is about to cross, to remember to slow down, and how to catch herself if she begins to fall. PT will give the parents ideas for practicing this skill on the playground, during their evening walks, and during shopping.

Other Example Strategies:

<u>Language/communication</u>

1. Look at the baby while talking to him/her

2. Make simple sounds with the baby (A,O, U, I) and listen for those sounds from the baby. Imitate sounds the baby makes and wait for them to make them again.
3. Read simple colorful books with your infant/toddler, everyday. Talk about the pictures on the page. Point to and label items on each page.
4. Point to and name body parts in play. Ask the toddler, "Where is your nose, eye, etc..." Encourage him/her to touch his/her nose.
5. Ask the toddler to get a single item that may be in another part of the room.
6. Continue to label everything seen and done throughout the day. Listen to the words your toddler says and show pleasure and excitement at his/her attempts to speak. You use correct pronunciation but it is not necessary to correct your toddler pronunciation at this time.
7. Model two word phrases when the child is interested in an object, food. or toy. Such as, more milk, ball please, and thank you.
8. Expand the phrases the toddler uses i.e. "big ball" to "big red ball", "mommy go" to "mommy go to work".

Motor Development:

1. Place alert infant on mat or rug in a SAFE part of the room to allow him/her to move without getting hurt, providing "tummy time".
2. Provide a variety of toys that the infant can reach for, look at, and bat at, such as an overheard "gym".
3. Provide toys that infant can easily grasp for and place in mouth. Provide items that are easy to grasp and move from one hand to another, such as rings.
4. Put baby on hands and knees with a toy just out of reach for stimulus.
5. Provide pieces of appropriate sized finger foods such as fruit or cheerios to encourage three-finger pinch.
6. Provide puzzles and items to sort. Provide containers to encourage filling and dumping.
7. Provide sturdy furniture and/or open arms to encourage a toddler to move toward you or an object.
8. Provide toddlers with large crayons and blank paper sit with him/her and talk about what they are making.
9. Encourage toddler to climb into your lap while seated. Provide low safe furniture for toddler to climb onto.
10. Play musical games that involve jumping to rhythms. Sing songs that involve the child moving fingers with the rhythm of the song.
11. Provide child with safety scissors and paper to cut (with supervision).

12. Allow toddler time and opportunity to begin to remove clothing during daily routines.

13. Allow child time to dress without being rushed.

Social/Emotional

1. Use words, facial expressions, and maintain eye contact with baby during everyday activities i.e. diaper change feeding, etc…

2. Recognize infant's signals and be responsive to them. Recognize infant's reactions and let them know that you are there for them.

3. Provide a flexible but predictable schedule, while keeping in mind that young infants have their own schedule in mind.

4. Include books, puppets, dramatic play, and role-play to allow him/her to express their feelings.

5. Provide opportunities for small group play to encourage friendships.

6. Promote cooperative play by modeling sharing and helping others in-group activities.

Cognitive:

1. Provide baby with different objects to mouth, explore and track with his/her eyes including cloth and vinyl books, mobiles and rattles.

2. Provide a variety of items/toys that makes things happen when the baby uses them.

3. Provide pots and pans, plastic container and lids and measuring cups that nest, simple rings and plastic puzzles

4. Name objects in a storybook or photographs as toddler points to them.

5. Routinely offer familiar books, toys, songs and finger plays.

6. Encourage toddler to find matching items like shoes socks, cups and plates, hat and mittens.

7. Offer opportunities to role-play daily routines such as feeding, dressing, cooking, and using the telephone.

8. Provides blocks that very in color and shape and encourage to sort by color and shape.

9. Encourage child to make predictions by asking "why" and "what if" questions.

Adaptations and/or Modifications: Indicate whether or not any adaptations and/or modifications will need to take place in order to support the attainment of this Goal.

Services to Consider: After Goals and strategies are determined, the FSP team can discuss who is most appropriate to support the family for each Goal. The FSP Team first reviews the family's current informal and formal supports and services and considers if any of these supports can address partially or wholly the Goals or if additional supports need to be identified. Effort should be made to eliminate duplication of services. Teams should determine a team configuration of the minimum number of people to address all Goals. Only those persons necessary to support a family-defined Goal, which has derived from a family-defined priority or concern, should be listed in this column. (e.g., Child has delays in communication and motor development. The family is not concerned about the child's communication development. Services to address the communication delay are not needed). List the members of the team that will work on that particular Goal (e.g., mother, father, physical therapist).

Date Reviewed: This section will allow for each Goal to be reviewed and document the review on the Goal Page. There are two reviews provided and as many pages can be added as needed.

Document the type of FSP review that is being held. And check the appropriate Goal Attainment Scale Score for each Goal. There is a comment section provided, if needed.

Section 11: Service Coordination Goals:

This section provides the format for defining individual Goals related to the child and family's needs. It includes the current status, specific objectives and strategies for addressing and achieving the Goal. If the family completes the resources, priorities ad concerns section of the FSP the FSP Team needs to consider this information when developing Goals.

#: Indicate the number of each service coordination goal,

Family-Identified Need: may be based on family's assessment of resources, priorities and concerns or as needs arise

Actions Taken: by family and service coordinator, may include providers of Other Services and involve teaming, advocacy, and linkages as appropriate.

Date Initiated/Date Completed: indicated the dates each service coordination goal was identified and addressed.

Section 12: FSP Team Signatures

Meeting Notes are to be used to capture the general discussion of the FSP Team meeting process, and in particular to note needs identified by the family, CBA provider, and/or service providers.

Type of FSP: Check the appropriate box for the type of FSP that is taking place

Parent Signature: The parent will sign and date the plan. If the plan is not signed and dated, it is not complete.

All other members of the FSP Team that are present will sign, list their agency (if applicable), complete the method code of their attendance, and date it the date of the FSP meeting. If an FSP team member participated in a manner other than attending, the SC/FT will print in their name and fill in the appropriate code for method of attendance.

Section 13: Medical/Therapy Updates: This section is included in order to document medical/therapy updates throughout the year. Document the date as the date the information is being written on the FSP. The narrative of the report should include the date of the appointment and the name of the physician and/or therapist. Each entry should include initial and title. **Only medical information that would affect the child's development is needed on the FSP.**

All updates must be mailed to the parent and other team members within 10 days of the meeting. The SC/FT will document this in the service notes.

Monitoring

Monitoring by the Early Interventionist occurs through activities to review and evaluate services and supports provided to the child and family or intended to be provided to the child and family. The purpose of monitoring is to determine the continued appropriateness and effectiveness of services and supports in meeting the needs, desires, and goals of the child and family as documented in the current FSP. Assessment of service quality and family satisfaction are important elements of monitoring. Monitoring may best be accomplished by using a variety of methods. These may include observation of services, in-person interview, mail correspondence, telephone calls, e-mail, and fax correspondence with the legal guardian, family, providers of services and supports received and appropriate others.

DDSN Specific Roles and Responsibilities related to Monitoring:

- DDSN contracts with an independent entity to conduct Contract Compliance reviews with all providers on an annual basis. Each provider receives a score in the areas of Administration, General Agency and Early Intervention.

- SCDDSN will conduct onsite reviews based on data collected at the state level. This data may show concerns about patterns of service delivery, extremely high and low service delivery hours, etc.

Provider Specific Roles and Responsibilities related to Monitoring:

- Services and supports must be monitored based upon the needs of each child/family to ensure that services are delivered as outlined in the child's plan. The frequency and intensity of monitorship should be based on the individual needs of the child and family, particularly those, which support the health and safety of the child. (Note: Both the MR/RD and HASCI waivers have specific monitoring requirements related to waiver funded services).

- All changes made to goals or services provided should be documented in the service notes and the changes made on the IFSP/FSP.

- If a child receives Service Coordination only, face to face contacts with the child and family should occur based on the frequency outlined in the IFSP/FSP, but must occur at least once per quarter. This would include the children receiving primary service coordination for BabyNet services from the School for the Deaf and Blind.

- Monitoring must be documented in service notes including the name and/or title of the person with whom the monitoring contact occurred.

- Monitorship schedules must be updated on a continuous basis as services are monitored. For example, if a child's annual plan date is December 20, 2005 and their six-month review is due on June 16, 2006, but the six-month review was completed on June 1, 2006, the next annual plan is due before December 1, 2006.

- While monitoring, if concerns are noted regarding a specific provider, the Early Interventionist should bring these concerns to the attention of their supervisor.

Record Keeping and Documentation

Case records maintained by the Early Interventionist are considered by SCDDSN to be the child's primary case records with DDSN. Primary case records should be logically and consistently organized. The contents should be current, complete, meet documentation requirements and permit someone unfamiliar with the child to quickly acquire knowledge sufficient to provide service coordination or planning for the child or to review the records to assure compliance with contract, policy, standard or procedure. Service notes should provide a clear description of the circumstances being recorded. If person-to-person contacts are being documented, the content of the service note should clearly record the name of the contact person (including title, position or relationship to the child), the purpose of the contact, assessment of the situation, services provided, and goal or follow-up needed. Confidentiality of records should be observed according to DDSN policy.

Record Keeping

1. The primary case record will be kept in a secure location. Provider and DDSN confidentiality policies are to be followed, and must comply with HIPAA laws.

2. The primary case record must have an index that is followed and the contents in each section must be in chronological order. The record index must be readily available to persons reviewing the records. (See attachment 1 for sample record index)

3. The primary case record must contain:

    - A valid SCDDSN service agreement; if a DDSN service has been identified as a need;
    - SCDDSN eligibility documentation, once received;
    - BabyNet eligibility documentation, if applicable;
    - Service notes;
    - A current FSP, previous FSP;
    - MR/RD or HASCI waiver documentation if enrolled in waiver;
    - Current medical records
    - Current provider records (therapies);
    - Most recent psychological, if available;
    - Birth records, if needed;
    - Current IEP, if applicable;
    - Correspondence and any other documentation intended to support Medicaid reimbursement for early intervention;
    - Legal records determining a change in legal guardianship or documenting a legal name change, if applicable;
    - Other documents which from time to time may be deemed essential by DDSN or the state Medicaid agency;

- Family training summary sheets;
- Genetics Release Form; and,
- Current (within1 year) age appropriate assessment, unless the child is enrolled in public school and has a current IEP addressing their educational needs.

4. Contents purged from primary case record must also be maintained according to the record index, in chronological order, and in close proximity to the primary case record. The primary case record must note that there is a file containing purged contents. If the child is enrolled in any waiver, all MR/RD Waiver documents must remain in the working file at all times.

5. Closed case records must be retained for a period of no less than six (6) years after the end of the annual contract period. If any litigation, claims, or other actions involving the records are initiated prior to the expiration of the six (6) year period, the records must be retained until completion of the actions and resolution of all issues which arise from it or until the end of the required period, whichever is later.

6. If a provider discovers that they have "lost" a consumer's case record this MUST be reported to the Office of Children's Services immediately. Private providers should also notify the agency that holds their sub-contract.

Record Transfer:

Once it is determined that a case needs to be transferred to another county or provider the following steps must be taken:

1. Offer the family a choice of provider and have the family sign the Acknowledgment of SC/EI Provider Choice form;
2. Contact the provider of parental choice to inform them of the transfer;
3. Copy and mail the original file within two working days;
4. You must reconcile the waiver budget if applicable;
5. You must update the CDSS with the new contact information if it is available;
6. The receiving provider must contact the sending provider to inform them of the receipt of file.
7. Transfer the child to the new provider in CDSS once receipt of file is confirmed;

If a child is transferring from the Early Intervention Program to Service Coordination, prior to transfer, the EI must be discharge the child from Family Training in the Services Menu (SVMEN) within STS.

Documentation in Service Notes

1. Service notes must document all service coordination and/or family training activity on behalf of the child. It is particularly important that notes address health, safety and legal issues when applicable or family/legal guardian concerns and expressions of choice when they occur. Multiple actions which support the same function (intake, needs assessment, planning, FSP implementation, etc.) may be incorporated into a single service note provided those actions occurred at or about the same time;

2. All service notes must be typed or handwritten in black or dark blue ink. Photocopies of service notes may be placed in the primary case record, temporarily, if the originals have been forwarded to DDSN and if the photocopies are legible. Photocopies of service notes documenting concurrent activity on behalf of two or more children is not acceptable. Service notes must be individualized to the specific child represented by the primary case record;

3. All service notes must be placed in the file within seven calendar days from the date the service was rendered;

4. All service notes must be legible and kept in chronological order;

5. All entries must be dated and legibly signed with the Early Interventionist's name or initials and professional title. A signature/initial sheet including all current Early Interventionists and supervisors must be maintained in the Early Intervention office;

6. Late entries (entries to provide additional documentation to supplement entries previously written) may be necessary at times to handle omissions in the documentation. Late entries should be rarely used, and then only used to correct a genuine error of omission or to add new information that was not discovered until a later date. Whenever late entries are made, providers shall adhere to the following guidelines: Identify the new entry as a "late entry", enter the current date and time, identify or refer to the date and incident for which the late entry is written, validate the source of additional information as much as possible, document all information as soon as possible;

7. Each Early Intervention office must maintain a list of any abbreviations or symbols used in the records. This list must be clear as to the meaning of each abbreviation or symbol. Only abbreviations and symbols on this approved list may be used;

8. Persons referenced in service notes or any supporting correspondence must be identified by relationship to the child either once on each page or on a separate list located in each record;

9. When errors are made in service notes:

    - Clearly draw one line through the error, write the word "ERROR", enter the correct information, and add the Early Interventionist's signature or initials and date. If additional explanation is appropriate, this may be included.
    - The information contained in the error must remain legible.
    - No correction fluid or erasable ink may be used.

10. When a review reveals that a service note was not signed when written, the note must be signed immediately and that signature given the current date. A current service note must be written to explain the difference between the signature date and the date the note was actually written. If the activity described in the unsigned note had previously been reported on the SPL, this is not considered a reporting error that must be corrected;

11. There must be a service note documenting an activity for each service reported;

12. The content of the service note will contain sufficient detail to clearly communicate the purpose of the note and to document reportable activity if such is the case. All service notes do not have to document a reportable activity;

13. Written correspondence, pertinent oral communications, completed reports and completion/updates to the FSP must be documented in service notes to include identification in the record of any referenced documents; and

14. Service notes must document activities relevant to the needs of the child and family. (See attachment 2 for a sample service note form)

Note: If an Early Interventionist is serving multiple children in one family, they must document each child's services separately to include; summary of visit sheet and service notes.

Record Index

Each agency has a different method of organizing information. The following information can be used as a template.

Section 1: File Index
Consent to release and obtain information
Consent for evaluation and assessment
Service Agreement
BabyTrac
CDSS
Review of record log
Once the case is closed place the Closure form on top of this section

Section 2: IFSP/FSP

Eligibility Certification Letter

Section 3: Service Notes

Section 4: Summary of visits/data sheets (For FT providers)
IEP

Section5: Medical/Therapy information
Psychological Evaluations

Section 6: This section must be tabbed for each of the following:

- BabyNet Intake Information.
- Written Prior Notice/Meeting Notification.
- BabyNet Payment Authorizations / BabyNet Insurance Payment Authorization.
- Correspondence (Letters, referrals, Transition referral form etc…)
- Request for information.
- If pursuing eligibility for DDSN services place information here (CIS, Eligibility cover letter).
- MR/RD Waiver information, if applicable.

Service Notes

Child's Name:_____

Date	Activity SC/FT	Time Hr/min	Description of activity

Procedural Bulletin # 13
Attachment # 2

Reportable Early Intervention Activities

Formerly known as "meaningful" or "billable" activities, reportable service coordination/family training activities are those broadly defined categories of activity that are made available to DDSN eligible persons and, to a limited extent, to those seeking DDSN eligibility. These categories are not mutually exclusive and, therefore, some activity(s) of the Early Interventionist may overlap two or more categories. Also, these are the primary early intervention activities for which DHHS contracts with DDSN and for which DDSN sub-contracts with local providers.

Activities such as counseling, transportation of a child or family member, or performing the duties of a child development staff as a result of their unplanned absence are not part of Early Interventionist's responsibility as contracted by DDSN. Likewise, recruitment of board-based caregivers, fund raising during normal business hours, general office management, and management of agency vehicles are not to be supported by Medicaid-funded early intervention. Of course there are certain non-early intervention activities that an employer may require of an employee and which commonly occur in a normal work environment, such as with DSN Board committees or inter-agency workgroups. These types of activities are acceptable, but are not reportable by the Early Interventionist.

Reportable activities will fall into one of the following activities:

1. **Intake Activity**-Intake includes activities, which lead to a determination of DDSN eligibility. Intake begins with referral and ends with notification of the parent/legal guardian (and the referring party if different and if appropriate) of the eligibility decision or ends with the conclusion of any subsequent appeal and notification. Activities include gathering information, which may support DDSN eligibility from the parent/legal guardian, family members, current and former service providers, and others who know the child. Information may be gathered by mail or electronic correspondence, telephone interview or face-to-face interview. Intake may overlap some of the other reportable activities, particularly, early needs assessment and plan development. Other reportable activities may occur during intake such as referral to a non-DDSN service provider to address an immediate need.

2. **Needs Assessment Activity**-Needs assessment includes activities to obtain, review and evaluate descriptive, diagnostic, treatment and evaluation information provided by the family and others who know the child/family on a personal or professional level. The purpose of needs assessment is to determine the needs, desires and goals of the child. Needs assessment is based upon a determination of the relative strengths and needs of the child/family's environmental, economic, psycho-social, medical and other circumstances. Personal observation and interview by the Early Interventionist is an important element of needs assessment. Needs assessment is directed at the child, though his/her needs and

resources may overlap with the family or others. Needs assessment by the Early Interventionist begins with referral for DDSN eligibility and ends with closure of the case.

3. **FSP Development (Planning) Activity**-FSP development includes activities leading to a comprehensive plan that identifies and documents the needs, goals, and desires of the child/family and that identifies and documents the services and supports required to address them. If the parent/legal guardian chooses to plan with the assistance of a facilitator (for DDSN children ages 3-6 only), an important function of Early Interventionist in FSP development is the coordination of information and/or communication with the family, persons who play an important or meaningful role in the child's life including current or potential service/support providers, and the facilitator. Planning which involves the Early Interventionist begins with referral for Early Intervention Services, eligibility and ends with closure of the case.

4. **FSP Implementation Activity**-FSP implementation includes activities to identify, refer, link, or access new services/supports or to maintain and coordinate services/supports currently received which address the needs, desires and goals of the child/family as documented in the current FSP. As needs, goals, and desires of the child/family change, FSP implementation will be revised in order to identify and access the most effective services and supports.

5. **Crisis Intervention Activity** -Crisis assessment includes activities required as a result of crisis circumstances arising in the life of the child and family. These circumstances require immediate action to assess and address. The crisis may or may not be associated with known factors in the child's life and, most probably, the needed services/supports or required actions will not have been previously identified in the FSP. Early Interventionists recognize and report situations, which put the child and family at risk of health, safety, or abuse/neglect.

    - The Early Interventionist recognizes signs and symptoms of illness and takes action accordingly.

    - The Early Interventionist recognizes and assists the family to assure environments are free of fire and safety hazards.

    - The Early Interventionist recognizes signs and symptoms of abuse and neglect and when identified takes action accordingly.

6. **Advocacy Activity**-Advocacy includes activities to encourage a current or potential funding source or service provider to address the needs, desires and goals of the child. These activities may overlap with FSP implementation or may be in response to crisis circumstances. Activities should be on behalf of a specific child, though systems change may result from these activities. Good relationships with other agencies in the community are essential to children receiving all necessary services. The provider agency:

- Promotes positive community relations by assisting agency staff in their roles of public relations, community activities, and interagency relationships.

- Assist families and children in using community resources, building community relationships, and gaining access to public agencies, resources, and opportunities.

7. **Consultation Activity**-Consultation includes activities to confer about, seek information on, or discuss the child and family's goals, desires and services/supports with service agencies and professionals whether or not they are currently serving the child. These activities may overlap with FSP implementation, advocacy, or be in response to crisis circumstances.

8. **Monitoring Activity**-Monitoring includes activities to review and evaluate services/supports provided to the child or intended to be provided to the child in order to determine their quality, continued appropriateness and effectiveness in meeting the needs, goals and desires of the child as documented on the current FSP. Service quality and family satisfaction are important elements of monitoring.

Reportable Activity for the Individual Service Report

Early Interventionists are required each month to report on the Individual Service Report (ISR) for each person on their caseload.

1. **Initial Reporting**-Early intervention activity may be reported on the ISR once the child's case is opened on CDSS.

2. **FSP-**Early intervention activity may be reported on the ISR only when a current FSP is in place or when an FSP is in process according to time frames. Only service coordination is to billed prior to the initial FSP being completed.

3. **Reportable Defined**-Only activities which fall within the definitions of the reportable activities may be reported on the ISR.

4. **Intake Reporting Limits**-During the eligibility determination process, reporting may occur for up to 6 months after the provider choice is offered in the screening process. If at 6 months eligibility is not determined reporting must be discontinued until such time as eligibility is determined. SCDDSN may reduce provider's contract or payments if the intake delay is the fault of the provider.

5. **Child Not Located**-If a DDSN eligible person is missing and his/her whereabouts can not be determined within 30 calendar days, an Early Interventionist must discontinue reporting activity and close the case.

6. **Service Provider Reports**-The reading of reports from service providers in and of itself is not reportable. Service notes should document the reading as a part of needs assessment, planning and/or monitoring and the information should be recorded in the FSP in order for this activity to be reportable.

7. **Family Training**-The following activities are to be reported under family training:

   - Activities to enhance development, teaching skills, parenting, play and recreation.
   - Providing information regarding child's diagnosis and development.
   - Encouraging participation of the child in typical family activities.
   - Encouraging parents to provide their own service coordination, advocacy, and transition.
   - Developmental assessments.
   - When reporting time for siblings who received family training at the same time, the Early Interventionist must split the reportable time. For example, if you provide SI to two brothers during a one hour visit you should report 30 minutes of SI for each child not one hour for each brother.

9. **Authorizing Services**-For children birth to three, BabyNet Service Funds are reportable when properly documented. It is not sufficient to document that the Early Interventionist completed the form. The documentation must note that the Early Interventionist is completing the BNSF in order to authorize a service as identified on the plan.

10. **Reporting/Transfer of Case-**If a child transfers from EI to SC in the middle of the month both the EI and the SC can report their activities. Also if the child transfers from one EI provider to another both EI's can report their activity. The former EI would report the activity for the time that she/he had the case and the new EI would do the same.

Guidance for Prep Time -the following guidance is provided as it relates to time spent preparing for family training visits:

- The amount of time it takes to prepare for a scheduled home visit should reflect the activity that was planned for that day. (For example, if an Early Interventionist prepared to sing songs and work on body parts during a particular family training visit the prep would most likely be low).

- There should **not** be a "set" amount of time for preparation of family training activities. The amount of time it takes to prepare for a visit should vary in time depending upon the activity being planned with the child and family.

- If an Early Interventionist prepares for a family training visit, and reports that prep time in the service notes, and the family is not there time should not be reported for the following family training visit.

- Prep time for Family training should be reported as Service Coordination.

Guidelines for Early Intervention Activities that should not be reported:

The following activities, while important in their own right, are not reportable on the ISR's.

1. Activities on behalf of deceased children or their families even though Early Interventionists may be asked to perform such activities at that time.

2. Verification of Medicaid numbers.

3. Medicaid eligibility determinations and re-determinations (Activities on behalf of a TEFRA Medicaid applicant seeking ICF/MR level of care are not reportable because this is part of a Medicaid eligibility process. Activities to gather information for an ICF/MR level of care with the intention of obtaining ICF/MR placement or waiver services are reportable.).

4. Transportation of child or family members for any purpose. Exception: the time spent during transport that reflects an Early Interventionists rendering a reportable service, such as role playing with the parent for the task ahead; instructing the parent regarding issues with the child. This reportable time must be documented accordingly.

5. Attempted reportable activities which were never completed (The attempt should be documented) telephone calls, home visits, and/or other face-to-face contacts.

6. Review of the child's primary case record (Such as might occur when the child is new to the caseload).

7. Provision of information about a child for administrative purposes (Such as during a contractual compliance review).

8. Participation in recreational or social activities with the child or family just for social reasons.

9. Activities rendered during court proceedings (South Carolina Family Court, General Sessions Court, or Federal Court) which are convened to address criminal charges.

10. Activity with consumers in institutional settings (Such as nursing homes, ICF/MR, individual rehabilitation centers, or correctional facilities) Planning, which is normally a reportable activity, may need to begin prior to institutional discharge. Exception: time spent with child and parent while child is hospitalized in a medical, non-psychiatric hospital may be reported if the time is spent working on issues such as developing goals for the IFSP/FSP.

11. The act of writing service notes.

12. Completing statistical reports.

13. Clerical activity such as typing, copying, faxing, and filing.

14. Form letters not personalized to the individual and/or reflective of an individual need.

15. Completing forms for DDSN Family Support funding (Discussion with the parent/legal guardian and the gathering of information to support the request may be reportable.)

16. Services to a hospice recipient unless a prior authorization has been obtained from the hospice provider.

17. Time spent traveling to and from the various locations where services are rendered.

18. Time spent attending provider, regional, and/or central office trainings or other agency trainings.

19. Group activities.

20. Submission of changes to any CDSS or BabyTrac or review of documents of such systems.

21. Observation of a child. Exception; Observing for assessment and FSP development purposes.

22. Providing emotional support and/or counseling is not reportable. Exception: providing information in a crisis situation.

23. Participating in activities such as going shopping with family for toys for the child. Exception:
    1.) trip to BabyNet loaner closet or other source to seek a specific type of item needed by the child/parent;
    2.) due to some impairment(s) of the child or the parent, the El may need to go to the toy store and help a parent understand why a toy is or is not beneficial. There should be clear documentation to support why the early interventionist participated in this activity. Documentation will show this is a family training activity.

24. Services provided directly to the child in the absence of a parent.

25. If the FSP expires, the Early Interventionist cannot report activity on an ISR during expiration. SCDDSN may reduce provider contract or payment accordingly. A service note entry should be made documenting why time is not being reported but the notes should continue to show time spent on activities. When the FSP has been completed the time may be reported on the ISR.

26. Providers that chose to require forms (i.e., Social History) that are no longer required per DDSN Standards, may choose to continue to complete these forms, however, the completion of these forms is not reportable.

27. EI's should not report **ANY** service that is provided once the child turns six years old.

28. EI's should not report **ANY** services once the child's DDSN eligibility has expired, unless the child is also BabyNet eligible. This includes children who were being served "High-risk" whose eligibility ends on their third birthday. If eligibility has not been established under another category by the child's third birthday, services should not be reported. If service are provided to a consumer whose eligibility has expired, these should be documented in the service notes but NOT reported on the automated billing system. The service notes should explain why services are not being reported.

29. Family Training should not be provided at agency sponsored functions.

Case Management Overlap

These case management/service coordination and hierarchy guidelines of the Department of Health and Human Services are intended to assist Early Interventionists in understanding their roles and their service reporting responsibilities when a DDSN child has multiple Medicaid funded case managers.

Some children who are dually diagnosed or have complex social and/or medical problems may require services from more than one case management provider to be successfully managed and/or integrated into the community. The needs and resources of each child may change over time as well as the need for case management services from another provider. Case management providers must work closely and cooperatively if recipient needs are to be adequately met and duplication of services and Medicaid payments are to be avoided. A system must exist within each case management program to assure that service providers are communicating, coordinating care and services, and adequately meeting each child's need.

Case Management Hierarchy Guidelines:

A primary case manager as well as a secondary provider for each overlapping situation has been determined. The Primary Case Manager, shall: a) ensure access to services, b) arrange needed care and services, c) monitor the case on an on-going basis, d) provide crisis assessment and referral services, e) provide needed follow-up, and f) communicate (telephone or face-to-face) regularly with other involved agencies/providers.

Concurrent Care shall be rendered to an individual in which another provider has been designated the Primary Case Manager. The Concurrent Care provider shall timely notify the Primary Case Manager about: a) changes in the client/family situation they have identified, b) needs, problems or progress, c) required referrals and, d) treatment/service planning meetings. The Concurrent Care provider will render different, distinctive types of services from the Primary Case Manager. Billing is restricted to specific activities.

Ancillary Service providers will render treatment related case management –like services. Ancillary Services procedure codes have been set up for each Ancillary Services provider.

If overlap occurs, these guidelines shall be followed:

KEY:

CCEDC =Continuum of Care for Emotionally Disturbed Children
CLTC =Community Long Term Care
DAODAS =Department of Alcohol and Other Drug Abuse Services
DDSN =Department of Disabilities and Special Needs
DMH =Department of Mental Health
DSS =Department of Social Services
MTS =Managed Treatment Services
SCSDB =South Carolina School for the Deaf and Blind

CCEDC/DSS Foster Care and DSS Adult Protective Services: CCEDC primary case manager with DSS providing concurrent care.

CCEDC/MTS: Overlap between these two programs is not permissible.

CCEDC/Sickle Cell: CCEDC primary case manager with Sickle Cell providing ancillary services.

CCEDC/DDSN Service Coordination: CCEDC primary case manager with DDSN providing concurrent care.

CCEDC/DDSN Early Intervention (El): CCEDC primary case manager with El providing concurrent care.

CCEDC/DMH:CCEDC primary case manager with DMH providing ancillary services.

CCEDC/DAODAS: CCEDC primary case manager with DAODAS providing ancillary services.

CCEDC/CLTC: CLTC primary case manager with CCEDC providing concurrent care.

CCEDC/SCSDB - Commission For Blind: CCEDC primary case manager with SCSDB Commission for Blind providing concurrent care.

CCEDC/DJJ: CCEDC primary with DJJ providing concurrent care.

DDSN Service Coordination/DDSN Early Intervention Case Management: Overlap is not permissible.

DDSN/MTS: MTS primary case manager with DDSN providing concurrent care.

DDSN/DMH: DDSN primary case manager with DMH providing ancillary services.

DDSN/DAODAS: DDSN primary case manager with DAODAS providing ancillary services.

DDSN/Sickle Cell: DDSN primary case manager with Sickle Cell providing ancillary services.

DDSN/SCSDB - Commission For Blind: SCSDB - Commission for Blind primary case manager with DDSN providing concurrent care.

DDSN/CLTC: CLTC primary case manager with DDSN providing concurrent care. DDSN primary case manager for children (0 to 18) receiving CLTC Personal Care Aide Only services.

DDSN/DSS Foster Care and DSS Adult Protective Services: DDSN primary case manager with DSS providing concurrent care.
DDSN/DJJ: DDSN primary with DJJ providing concurrent care.

DDSN Early lntervention/DMH: DDSN primary case manager with DMH providing ancillary services.

DDSN Early Intervention/DAODAS: Overlap not anticipated.

DDSN Early Intervention/Sickle Cell: DDSN primary case manager with Sickle Cell providing ancillary services.

DDSN Early lntervention/SCSDB - Commission for Blind: SCSDB primary case manager with DDSN providing concurrent care. DDSN primary case manager with Commission for Blind providing concurrent care.

DDSN Early Intervention/CLTC: CLTC primary case manager with DDSN providing concurrent care. DDSN primary case manager for children (0 to 18) receiving CLTC Personal Care Aide Only services.

DDSN Early lntervention/DSS Foster Care: DDSN primary case manager with DSS providing concurrent care.

DDSN Early lntervention/DSS Adult Protective Services: Overlap is not anticipated.

DDSN Early lntervention/DJJ: Overlap not anticipated.

DDSN Early lntervention/MTS: MTS primary case manager with DDSN providing concurrent care

DMH/MTS: MTS primary case manager with DMH providing ancillary services.

DMH/DAODAS: DMH primary case manager with DAODAS providing ancillary services for a client with a psychiatric disability & substance abuse problem. For other dually diagnosed clients, whichever agency is pre-dominantly meeting treatment needs will be primary CM.

DMH/Sickle Cell: Sickle Cell primary case manager with DMH providing ancillary services.

DMH/SCSDB - Commission For Blind: SCSDB - Commission for Blind primary case manager with DMH providing ancillary services.

DMH/CLTC: CLTC primary case manager with DMH providing ancillary services.

DMH/DSS Foster Care and DSS Adult Protective Services: DSS primary case manager with DMH providing ancillary services.

DMH/DJJ: DJJ primary case manager with DMH providing ancillary services

DAODAS/Sickle Cell: Sickle Cell primary case manager with DAODAS providing ancillary services.

DAODAS/SCSDB - Commission For Blind: SCSDB - Commission for Blind primary case manager with DAODAS providing ancillary services.

DAODAS/CLTC: CLTC primary case manager with DAODAS providing ancillary services.

DAODAS/DSS Foster Care and DSS Adult Protective Services: DSS primary case manager with DAODAS providing ancillary services.

DAODAS/DJJ: DJJ primary case manager with DAODAS providing ancillary services.
DAODAS/MTS: MTS primary case manager with DAODAS providing ancillary services.

Sickle CeII/SCSDB - Commission For Blind: SCSDB - Commission for Blind primary case manager with Sickle Cell providing ancillary services.

Sickle CeII/CLTC: CLTC primary case manager with Sickle Cell providing ancillary services.

Sickle Cell/DSS Foster Care and DSS Adult Protective Services: DSS primary case manager with Sickle Cell providing ancillary services.

Sickle Cell/MTS: MTS primary case manager with Sickle Cell providing ancillary services.

Sickle Cell/DJJ: DJJ primary case manager with Sickle Cell providing ancillary services.

SCSDB -Commission For Blind/CLTC: Overlap not anticipated between SCSDB and CLTC.

CLTC primary case manager with Commission For the Blind providing concurrent care.

SCSDB Commission For Blind/DSS Foster Care and DSS Adult Protective Services: SCSDB/Commission For the Blind primary case manager with DSS providing concurrent care.

SCSDB Commission For Blind! MTS: MTS primary case manager with SCSDB and Commission For Blind providing concurrent care.

SCSDB Commission For Blind/DJJ: SCSDB primary case manager with DJJ providing concurrent care. DJJ primary case manager with Commission For Blind providing concurrent care.

CLTC/DSS Foster Care and DSS Adult Protective Services: CLTC primary case manager with DSS providing concurrent care.

CLTC/MTS:CLTC primary case manager with MTS providing concurrent care.

CLTC/DJJ: CLTC primary case manager with DJJ providing concurrent care.

DSS Foster Care/MTS: Overlap between these two programs is not permissible except that MTS may bill for attendance at Interagency Staffings.

DSS Foster Care/DJJ: DSS primary case manager with DJJ providing concurrent care.

OTHER CRITERIA/SPECIAL RESTRICTIONS:

1. Each provider shall be responsible for: a) attempting to identify during the intake process whether an applicant is already receiving case management services from another Medicaid provider and b) notifying any other involved Medicaid case management providers of an applicant's request for services.

2. Each provider must bill Medicaid according to Case Management Hierarchy guidelines for each individual receiving case management services from another Medicaid provider.

3. Needed services should never be denied to an individual because another provider has been designated the Primary Case Manager.

4. Each provider shall timely notify other involved agencies or providers if an individual in an overlapping situation terminates their services.

EXCEPTIONS TO THE HIERARCHY/RESOLUTION PROCESS

Each provider is encouraged to resolve any exceptions to the Case Management Hierarchy at the local level. When an exception exists, these guidelines must be followed:

1. If a Concurrent Care provider or an Ancillary Services provider is predominantly meeting the treatment **and** service needs of the individual **OR** if the Primary Case Manager has failed to adequately coordinate care and services, the Concurrent Care provider or Ancillary Services provider may initiate contact with the Primary Case Manager at the local level to request a change in the Primary Case Manager. A meeting should be set up between the two agencies to discuss the feasibility of a change in the Primary Case Manager.

2. Contacts (telephone or face-to-face) between the Concurrent Care provider or Ancillary provider and the Primary Case Manager concerning a change in Primary Case Manager as well as the final determination of a Primary Case. Manager must be documented in each provider's case management record. Although documentation of these activities is required, the activities are administrative and are not reimbursable by Medicaid.

3. If the local providers are unable to reach a determination of the most appropriate Primary Case Manager, the case should be referred to the appropriate state agency levels or main office for review.

4. If the state agency or main office administrators are unable to reach a determination of the most appropriate Primary Case Manager, the case should be referred to the Department of Health and Human Services for review.

5. The Department of Health and Human Services may make the determination of the most appropriate Primary Case Manager or may request that a team of other agency representatives make the determination.

6. The involved Medicaid providers will be notified within forty-five (45) days after the case is received by the Department of Health and Human Services whether a change in the primary case manager is warranted.

Early intervention providers use many words and acronyms with which readers may not be familiar. The following is a list of some of those most commonly used.

Glossary

Americans with Disabilities Act-(ADA). Federal legislation to prohibit discrimination on the basis of disability in employment, public services, telecommunications, and public accommodations.

Adaptive Behavior- Skills that children develop that allow them to take care of themselves and become independent (such as feeding, eating, and dressing).

Advocate- Someone who takes action on someone's behalf.

Apnea- Pauses in breathing usually greater than 15 seconds.

Appeal- A written request for a change in a decision; also, to make such a request.

Assessment- A process using observation, testing and interview to determine an individual's strengths and needs in order to develop a plan for intervention services.

Assistive Technology- Equipment or devices used to increase, maintain, or improve the capabilities of an individual with disabilities. Also includes evaluation to determine the need for equipment, instruction in the use of the equipment, and on-going monitoring of the use of the equipment.

At-Risk Child-An eligibility category which includes children from age 3 (36 months) to age 6 whose diagnosis of a developmental disability (e.g., Mental Retardation or a Related Disability) remains unclear. It may still be too early to confirm a diagnosis of Mental Retardation and Related Disability at this age range since developmental delays evidenced during the preschool years may still not be good predictors of later cognitive and adaptive functioning.

Atypical Development- Unusual development of behavioral or emotional skills, such as lack of interest in other children or adults, not being able to pay attention, extreme fearfulness or distress, or becoming easily frustrated.

Audiology- Includes any services or equipment that may be needed to address a child's needs with relation to his auditory skills. An audiologist is a professional who identifies children with auditory impairment.

Augmentative Communication- A collection of techniques, symbols, equipment and interaction strategies to facilitate communication, which may include sign language, picture boards, electronic communication devices, microcomputers or a combination of systems.

Autism-Abnormal or impaired development in social interaction and communication, as well as markedly restricted, repetitive and stereotyped patterns of behavior, interests and activities manifested prior to three years of age.

BabyNet-A program operated by the SC Department of Health and Environmental Control (DHEC) which provides services to infants and toddlers, birth to 3 years of age, with developmental delays or diagnosed disabilities. Children may be eligible for BabyNet if they are learning or developing slowly. Early Intervention services are based upon the child's needs and may include physical therapy, occupational therapy, speech therapy or assistive technology.

Bond- An emotional tie or attachment between caregiver and infant.

Chronological Age-The actual age of a person.

Child Abuse Prevention and Treatment Act (CAPTA)- Requires that states develop provisions and procedures to ensure that children under age three with substantiated abuse and neglect be referred to the state's early intervention services.

Child Development Center-A name used by some child care programs.

Central Directory of Resources (CDR)- Provides information and referral services for families and professionals.

Council for Exceptional Children/Division for Early Childhood (CEC/DEC)- A national non-profit organization of individuals who work with or on behalf of children with special needs, birth through age eight, and their families.

Centers for Medicare and Medicaid Services (CMS)- Formerly known as the Health Care Financing Administration. This is the federal agency which administers and oversees state Medicare and Medicaid operations and provides health insurance through these two programs and the state Children's Health Insurance Program.

Cognitive Development- Skills and knowledge that children develop that allow them to think, learn, problem solve, and remember.

Communication Development- Skills that a child develops as he grows that allows the child to tell others what he wants by using signs, sounds, and gestures when he is very young (such as looking and pointing) and using verbal language (speech) as he gets older.

Congenital Condition or Anomaly- A condition present since birth.

Child Protective Services (**CPS)-**Under the county Department of Social Services. Ensures that children are protected and safe from harm. Investigates reports of abuse and neglect.

Cross Walk- The process of matching one set of data elements or individual code values to their closest equivalents in another set. This is sometimes called data mapping.

Comprehensive System of Personnel Development (CSPD)-Outlines the basic requirements and training opportunities for early intervention personnel.

Developmental age-The age at which a person is currently functioning.

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Developmental disability or delay-There is no single definition: different programs use different definitions. In common understanding, it refers to an impairment and is usually associated with functional limitations.

Developmental Delay- Refers to an impairment usually associated with functional limitations.

Developmental Milestones- The skills a child learns at certain times throughout infancy and childhood (e.g., sitting, crawling, walking, etc.).

Department of Health and Human Services (DHHS)-Agency responsible for ensuring the administration of Medicaid to eligible South Carolinians.

Durable medical equipment (DME)-Equipment that is non-disposable to promote and enhance access to and function in the environment for persons with disabilities.

Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)-Provides a comprehensive classification of all recognized psychiatric disorders.

Department of Social Services-The agency responsible for providing services to children and adults who are threatened by actual or potential abuse or neglect. DSS provides necessary services without regard to income eligibility.

Early Head Start- Early Head Start (EHS) is a federally funded community-based program for low-income families with infants and toddlers and pregnant women. Its mission is simple: to promote healthy prenatal outcomes for pregnant women, enhance the development of very young children, and promote healthy family functioning.

Early Intervention- Identification of young children who have a developmental delay or may be at-risk for developing a problem and then providing different types of services to support the family and the child. Early intervention services are provided by many agencies.

Early Periodic Screening, Diagnosis and Treatment program (EPSDT)-Health screening immunizations, and treatment for Medicaid eligible children.

Effectiveness- Under real life conditions, how well a treatment, therapy, or procedure produces a desired health outcome (e.g., cure, alleviation of symptoms, alleviation of pain, return of functional abilities).

Efficacy- Under ideal conditions, how well a treatment, therapy, or procedure produces a desired health outcome (e.g., cure, alleviation of symptoms, alleviation of pain, return of functional abilities).

Emotional development- The basic sense of self that a child develops about himself as a person. The skills and abilities needed to understand and respond.

Empowerment- A feeling of self-worth that allows people to define their own goals and make decisions and choices for themselves that meet their needs and priorities.

Facilitated Planning-A method used to develop a person-centered plan. A Facilitator guides the individual and the Circle of Support through the process of planning for the immediate and long-term future. A Facilitator makes sure that the ideas and needs identified by the individual and the Circle of Support are addressed and included in the individual's plan.

Family Educational Rights and Privacy Act (FERPA)-Federal law that protects the privacy rights of students and parents.

Family Service Plan (FSP)-A process to plan services for a child 3-5 years old and his/her family and a written document of that process.

Fiscal Agent-The agency in each county that is responsible to manage and disseminate all funds for every consumer in that county.

Free and Appropriate Public Education (FAPE)-Required for children three to 21 years of age who have disabilities.

Fine Motor- Skills which include reaching and grasping, release of objects and pincer grasp, and visual fixation followed by refinement of each skill. Skills which children develop that rely on their small muscles, such as holding things, turning knobs, buttoning clothes.

Fiscal Year- The budget year. For Sorth Carolina state government, it is from July 1 to June 30. For the federal government, it is from October 1 to September 30.

Food stamps- A government program that provides free coupons to buy food to eligible low income families and individuals.

Fraud and Abuse- Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law. Abuse refers to provider practices that are not usually considered fraudulent, but which are inconsistent with sound medical, fiscal, or business practice, and may result in unnecessary costs to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. Abuse also includes beneficiary practices that result in unnecessary costs to the Medicaid program.

Failure to Thrive-A clinical term applied to an infant or young child who is failing to meet the growth standards for their age. Failure to thrive may be of either organic (biological) or nonorganic (psychosocial) origin.

Functional Assessment- Assessment that includes the parent's description of the child's medical and developmental history and abilities across developmental domains; discussion with the parents about their desires and concerns about when, where and how the child participates; an observation of the child within a familiar context (people, places, things); a focused assessment of specific areas. Functional assessment links intervention services to adaptive outcomes.

Functional Intervention- Services and supports provided in the context of the child and family's everyday routines, activities, and places that are developmentally appropriate and relevant to the family's life.

Guardian Ad Litem-"ad litem" is Latin for "for the trial". This means that a Guardian Ad Litem is a person that is the guardian for an individual who is involved in a trial or hearing. The way the law works, the Judge has to assume that a child, an individual with mental retardation, or a person in jail needs a temporary guardian to speak for them. The Guardian Ad Litem may not actually be needed, but the individual is entitled to one. The Guardian Ad Litem can be very useful for making phone calls and checking on court schedules. The Guardian Ad Litem's job ends when the trial or hearing is over.

Gross Motor- A combination of a child's strength, coordination, and balance of muscles for his movement skills. Skills that children develop which rely on their large muscles, such as crawling, sitting, and walking.

Head Start- Federal programs providing comprehensive health, educational, nutritional, social, and other services to "economically disadvantaged" preschool children and their families, in order to improve their chances for success in school.

High-risk- Conditions which have the potential for causing problems in a child's development.

High-Risk Infant-An eligibility category which includes children from birth to 36 months of age who are at a substantially greater risk for a developmental disability than the general population due to their genetic, medical or environmental history.

Health Insurance Portability Accountability Act (HIPAA)- A federal law which among other things protects the confidentiality of medical records and other personal health information. It limits the use and release of individually identifiable health information, gives patients the right to access their medical records, and restricts most disclosure of health information to the minimum needed for the intended purpose.

Home Board-The agency in each county that is designated as the 'single point of entry' for services in that county.

Human Rights-Human rights are international moral and legal norms that aspire to protect all people everywhere from severe political, legal, and social abuses. Examples of human rights are the right to freedom of religion, right to freedom of speech, the right to be treated with dignity and respect, etc…

Hyperactive- Increased or excessive activity or behaviors characterized by over activity, distractibility, impulsivity, and the inability to concentrate.

South Carolina Interagency Coordinating Council (SCICC)-An advisory group to the lead agency (DHEC) for the implementation of an interagency system of services for children birth to three.

Individuals with Disabilities Education Act (IDEA)-Federal law which requires special services for children birth to age twenty-one years with special needs. Part B provides for children age three to twenty-one. Part C provides for children birth to age three.

Individualized Education Program (IEP)-The written document that lists the services and resources a child with special needs will receive when they are eligible to receive their education through the public schools.

Individualized Family Service Plan (IFSP)-A process to plan services for a child 0-3 years and his/her family and a written document of that process. The process involves a joint effort between parents and specialists. The written document lists the early intervention services a child needs in order to grow and develop and services the family needs to help the child grow and develop.

Integration-In the disability context, the process of including individuals with disabilities in the environments, activities and social networks of other people. Sometimes used interchangeable with the term "inclusion".
Immunization-A drug, called a vaccine, which is injected into the body or swallowed to protect against certain diseases that can cause developmental problems or deaths in individuals.

Inclusion-A term used to describe services, which are provided to children with special needs in settings which also, serve those who do not have special needs. These services are typically located in a preschool, childcare center, accredited developmental day program, or day care home. When a child is in an inclusive setting, the early intervention service provider works with the child in that setting, as well as provides consultation, training, and support to the staff. Other terms often used are **natural environment and least restrictive environment**.

Infant morbidity-A baby born with a serious, permanent mental or physical disability.

Infant mortality-Infant death. A baby born alive that dies before his first birthday.

Intensive care-Highly specialized care given to individuals hospitalized for serious illness or injury.

Interdisciplinary-A type of team approach for providing evaluation and intervention. Interdisciplinary teams are composed of parents and professionals from several disciplines. Teams have formal channels of communication that encourage team members to share their information and discuss individual results. Various professionals assess children separately or together, and the team comes together to discuss the results of their individual assessments and to develop plans for intervention. While program planning is more collaborative than with the multidisciplinary approach, service delivery may still be done in isolation. (See multidisciplinary and transdisciplinary).

Language Development-Skills that a child develops as he grows that allow him to tell others what he wants by using signs, sounds, and gestures when he is very young [such as looking and pointing], and using words and phrases and sentences when he is older.

Legal Guardian-A person appointed by a Judge to look after an individual who cannot look after himself/herself. The guardian makes all decisions and signs all documents for the individual concerning any medical treatment or placement. If an individual has a legal guardian, documentation from the court should be obtained, if available, for the individual's file. For children under age 18, their parent(s) are considered to be the legal guardian unless the parents' rights have been terminated or the parents are deceased.

Level of Care (LOC)-An assessment of an individual's disability and treatment needs. The Level of Care assessment must demonstrate that an individual requires the degree of care provided in an institution. Level of Care assessments are completed for MR/RD Waiver, HASCI Waiver and TEFRA consumers. The Consumer Assessment Team (CAT) completes LOC's for TEFRA and makes the initial determination for ICF/MR Level of Care for MR/RD and HASCI Waivers. Service Coordinators complete subsequent ICF/MR Level of Care annually (except At Risk and Time Limited Eligibility, which are done by CAT.) The initial Nursing Facility Level of Care is completed by a nurse from Community Long Term Care for HASCI and each subsequent Level of Care is completed by the Service Coordinator.

Local Education Agency (LEA)-A term used to describe the local public school system.

Low birth weight-A baby who weighs less than 3 pounds 5 oz. (1500 grams) at birth.

Least Restrictive Environment (LRE)-An educational setting or program that provides a child with special needs opportunities to work and learn to the best of his ability. It also provides the child with as much contact as possible with children without disabilities, while meeting all of the child's learning needs and physical requirements.

Mainstreaming-A term that was used widely in the 1970's to refer to the practice of placing students with disabilities in the regular education curriculum. This term lost favor when it was found that many students were being placed in regular classes without needed supports.

Medicaid-government program that pays for health care for people with low income.

Medical Home-An approach to providing health care services in a high-quality and cost-effective manner. Children and their families who have a medical home receive the care that they need from a pediatrician, physician, nurse practitioner, or physical health extender whom they know and trust. The pediatric health care professionals and parents act as partners in a medical home to identify and access all the medical and non- medical services needed to help children and their families achieve their maximum potential.

Mental Retardation-A condition with an onset prior to the age of 18 in which an individual demonstrates significantly below-average intellectual functioning (a valid IQ of 70 or below), and has concurrent deficits in adaptive functioning in at least two areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety.

Natural environment-Settings that are natural or normal for the child's age peers who have no disability.

Natural Supports-Supports that are non-paid which will help an individual to achieve personal goals or needs as identified on the Plan. Natural supports may include people such as family members, friends, church members, neighbors or community organizations. Natural supports may also be any location or event in the natural environment from which an individual may benefit or participate in such as community parks, civic events, etc.

National Early Childhood Technical Assistance Center (NEC*TAC)-A federally funded, nationwide system of technical assistance and support for states implementing birth to five services for children with special needs and their families.

Neonatal-Pertaining to the first 4 weeks after birth.

Neonatologist-A doctor specially trained in the care of babies who are premature or very ill.

Neonatal Intensive Care Unit (NICU)-The unit in the hospital that cares for premature infants and very ill babies until they are transferred to the regular nursery.

Non-reportable-Any activities of Service Coordinator's which do not fall within the core job functions as defined in the Service Coordination Standards, but are still important, relevant activities in providing quality person-centered services for individuals and families.

Nutritionist-A pediatric nutritionist is a certified specialist who assesses a child's growth, dietary intake, and feeding skills, makes recommendations, and provides intervention in the area of nutrition.

Orthotics/Orthoses-A rigid or semi-rigid device which is used for the purpose of supporting a weak or malformed limb or restricting or eliminating motion in a diseased or injured part of the body. For example: A brace or a splint.

Office of Special Education Programs (OSEP)-The federal agency responsible for oversight of the Individuals with Disabilities Education Act.

Occupational Therapy or Occupational Therapist (OT)-Services provided by a qualified occupational therapist who works with children to develop their fine motor skills.

Part B Services-Services provided by the public school system under the Individuals with Disabilities Education Act for children with special needs age three to twenty-one.

Part C Services-Services provided by the Infant-Toddler Program under the Individuals with Disabilities Education Act for children birth to three years old.

Peer Review- Mechanism of assuring quality of care provided by a health care professional. Other health care professionals (peers) conduct a quality assurance review to ensure that the services and care provided is appropriate. It is also used to identify fraud and other abuses of health care payment systems.

Physical Development- Skills that a child develops that allow him to use his large muscles (gross motor) and small muscles (fine motor). As defined by Part C of the Individuals with Disabilities Education Act, physical development also includes the areas of vision and hearing.

Pediatric Intensive Care Unit (PICU)-The unit in the hospital that cares for babies and children who are seriously ill or injured until they are transferred to the pediatric unit. including the Infant Toddler Program. Specifically manages Children's Developmental Services

Premature-A baby who is born too early, usually before the 35th week of the pregnancy and weighing less than 5 lb. 8 oz.

Preschool Coordinator-The person responsible for coordinating Preschool Programs in the public schools at the local or state level.

Preschool IEP Team-The group that determines eligibility, develops Individualized Education Program, makes placement decisions, and plans services for the Preschool Program under the Individuals with Disabilities Education Act.

Preschool Program-Early intervention services for children ages three and four years. In North Carolina, these are provided by, or under the supervision of local public school systems. Because of differences in eligibility rules, not all children who receive Infant-Toddler Program services will qualify for the Preschool Program

Primary Care Provider-Generally, most insurance plans allow family physicians, pediatricians, or general internists to serve as primary care providers. Sometimes, obstetricians, gynecologists, nurse practitioners, certified nurse midwives, or physician assistants can be primary care providers. Primary care is distinguished from specialty care, which is often concerned with a particular health condition. In some Health Maintenance Organizations, services provided by specialists or other practitioners will require a referral by the child's primary care provider in order for the health plan to cover the cost of care.

Prosthetics/Prostheses-A device that replaces a missing body part.

Protection and Advocacy (P & A)-Federally funded organizations located in every state that protect the rights of individuals with developmental disabilities.

Provider-An organization or agency paid to provide a service for a consumer. Two types of providers are included on the Qualified Provider List (QPL): DSN County Board providers, who directly contract with DDSN and are the single point of entry for consumers served by the agency; and private providers, who are those agencies who do not contract directly with DDSN. They contract through a DSN County Board or with the Department of Health and Human Services (DHHS) directly. Services may also be provided to consumers by agencies and funding outside the DDSN service delivery system.

Psychologist-A specialist in the field of psychology, usually with a Master's degree or Ph.D. in psychology.

Physical Therapy or Physical Therapist (PT)-Services provided by a licensed physical therapist who work with children to develop their gross motor skills.

Qualified Provider List (QPL)-Stands for "Qualified Provider List". A list of agencies which are approved to provide services within the DDSN system.

Quality Assurance-Quality assurance activities verify that the services and supports provided meet all required quality standards. Targeted areas include ensuring that services are minimally adequate, child and family rights are protected, organizations are fiscally sound, documentation requirements are met, providers comply with established standards, and relevant licensure and certification requirements are met.

Quality Improvement-Quality improvement activities involve constantly seeking new and improved ways of providing services and conducting business. Aspects of quality improvement include the selection and systematic assessment of performance indicators to guide decision making and aid in the achievement of better outcomes for children and their families, the identification and evaluation of trends, and the gathering of feedback from consumers regarding their satisfaction with service delivery.

Related Disabilities-Severe, chronic conditions which are found to be closely related to mental retardation or which requires treatment similar to that required for individuals with mental retardation. (e.g. cerebral palsy, epilepsy, etc.) Onset of a Related Disability must be before the age of 22.

Reportable-Any activities of Service Coordinators which fall within one of the core job functions as defined in the Service Coordination Standards. These core job functions are the only activities for which Service Coordinators may bill.

Related Services-In the public school system, this refers to transportation, developmental, corrective, and other support services that a child with disabilities requires in order to benefit from education. Examples of related services include: speech-language and audiology services; psychological services; physical and occupational therapy; recreation; counseling; interpreters for the hearing impaired, and medical services for diagnostic and evaluation purposes.

Respite-Services provided to individuals unable to care for themselves; furnished on a short term basis because of the absence or need for relief of those persons normally providing care.

Routines Based-Use of predictable and repetitive sequences of naturally occurring play, caregiving, social and community activities and routines to develop functional skills throughout the day.

Section 504-A section to the Rehabilitation Act of 1973. A federal civil rights statute designed to eliminate discrimination of the basis of a disability in any program or activity receiving federal financial assistance.

Section 8 Housing-Refers to housing subsidized to low-income individuals by Housing and Urban Development (HUD).

Service Coordinator-Service Coordinator. Someone who acts as a coordinator of services and works in partnership with the family and the providers of these services.

Similar Disability-South Carolina Code of Laws does not define a similar disability, but does stipulate that a similar disability is not limited by early age of onset, is not a condition that culminates in death or worsens over time, is not dementia resulting from chronic disease or alcohol/drug use, and is not a neurological disorder related to aging. Muscular dystrophy, Multiple Sclerosis, Cancer, Parkinson's disease and other primarily medical conditions DO NOT qualify as a Similar Disability.

Social Development-A child's ability to develop social skills, such as laughing and smiling, which allow him to interact with other people.

Social-emotional development-Skills that a child develops as he grows that allow him to interact with others (playing, and responding to adults or other children), as well as to express emotions (laughing, crying, and talking about feelings).

Social Security Administration (SSA)-The agency that oversees the provision of Social Security Disability Insurance and Supplemental Security Income and related work incentives.

Social Work Services-A variety of services provided to children and families to assist them to achieve their optimum potential

Special education programs and services-Services or specially designed instruction for children from age three to twenty-one with special needs who are found eligible for such services by the local public school system.

Speech Language Pathologist (SLP)-Someone who provides speech-language services which includes identifying and working with children to develop speech and communication skills.

Speech language therapy-An intervention provided by a Speech Language Therapist or Pathologist which includes identifying and working with children to develop speech and communication skills.

Special needs-A term to describe a child who has disabilities, or is at risk for developing disabilities, and who requires special services to minimize or prevent the disability.

Special Needs Trust -A legal and financial arrangement to safeguard resources for individuals with developmental disabilities. This trust allows individuals to maintain resources without impacting their Medicaid eligibility.

Sudden Infant Death Syndrome (SIDS)-The unexplained death of an apparently healthy infant. Previously referred to as "Crib Death."

Supplemental Security Income (SSI)-Federal program that provides financial assistance for eligible children under 18 who are blind or have a seer disability or chronic illness. It also provides financial assistance to people who are 65 or older or are blind or have a disability or have little or no other resources and income.

Surrogate Parent-A person required to be assigned by the Individuals with Disabilities Education Act to represent a child and protect his rights when a parent or guardian is unknown or unavailable or the child is a ward of the state.

Temporary Assistance to Needy Families (TANF)-A cash payment program of state and federal monies used to provide financial assistance payments for families below certain income levels. Administered through the Department of Social Services.

Time-Limited Eligibility-A short-term eligibility status that is given to individuals (usually young children) for whom a diagnosis of Mental Retardation is suspected, but cannot be confirmed. Time-limited eligibility is assigned to individuals who test within the range of Mental Retardation, but who may experience factors which confound test results, calling into question the validity of the results. If the potential exists for these factors to abate or resolve in the future so that more valid test results can be obtained, a time-limited eligibility status will be assigned. Time-limited eligibility prevents the potential of assigning a premature or incorrect diagnosis of Mental Retardation to an individual, but it also allows an individual with suspected Mental Retardation to receive appropriate services until a firm diagnosis can be made.

Transition-Transition means moving from one service provider to another. A major transition for children with special needs and their families occurs when the child turns three years of age and is no longer eligible for the Infant-Toddler Program. The child must then begin receiving services from the Preschool Program, if eligible, or from other service providers in the community.

Treatment and Education of Autistic and related Communication handicapped Children (TEACCH)-A program whose primary aim is to prevent unnecessary institutionalization by helping prepare individuals with autism and other related communication disabilities to live and work more effectively at home, at school, and in the community.

TRICARE-Civilian Health and Medical Program of the Uniformed Services. A health and medical program that provides benefits for eligible dependents of the military.

United Cerebral Palsy-Advocacy organization focusing on the needs of children and adults with cerebral palsy. Directly operates services in some communities.

Vaccinations-Another name for the medicine or immunizations given to protect individuals against certain contagious diseases.

Vocational Rehabilitation-Offers job readiness and job training services for youth and adults with developmental disabilities.

Women, Infants and Children (WIC)-Provision of nutrition education, supplemental foods (including formula), breastfeeding promotion and support, and referrals to health care for women, infants, and children.

Acronyms

Throughout your time in Early Intervention (EI), you will run across many acronyms through reading and verbal communication. This list contains the most common acronyms used in EI.

ADA: Americans with Disabilities Act

ADD: Attention Deficit Disorder

ADHD: Attention Deficit Hyperactivity Disorder

ASQ-SE: Ages and Stages Questionnaire-Social/Emotional

CA- Chronological age

CNS: Central Nervous System

CP: Cerebral Palsy

DB: Decibel (Hearing level)

DD: Developmental Disabilities or Developmental Delay

DHEC: Department of Health and Environmental Control

DDSN: Disabilities and Special Needs

EC: Early Childhood

EEG: Electroencephalogram

EI: Early Intervention or Early Interventionist

EKG: Electrocardiogram

EOB: Explanation of Benefits

FAPE: Free and Appropriate Public Education

FAS: Fetal Alcohol Syndrome

FT: Family Training

IDEA: Individuals with Disabilities Education Act

IEP: Individual Education Program

IFSP: Individualized Family Service Plan

LEA: Local Education Agency

LRE: Least Restrictive Environment

MR- Mental retardation.

OSEP: Office of Special Education Program

OT: Occupational Therapist or Therapy

OTA: Occupational Therapy Assistant

P&A: Protection and Advocacy

PA: Personal Attendant

PEDS: Parent Evaluation of Developmental Status

PL 94-103: Developmental Disabilities Act of 1975

PL 94-142: Education of All Handicapped Children Act of 1975

PL 93-112: Rehabilitation Act of 1973- Federal Legislation that expanded federally funded rehabilitation services to persons with severe disabilities

PT: Physical Therapist or Therapy

PTA: Physical Therapy Assistant

REELS: Receptive Expressive Emergent Language Scale

RN- Registered Nurse

SCSDB: South Carolina School for the Deaf and Blind

SLP: Speech/Language Pathologist

SSA: Social Security Administration

SSDI: Supplemental Security Disability Income

SSI: Supplemental Security Income

TECS: Team for Early Childhood Solutions

TBI: Traumatic Brain Injury

TTY: Teletypewriter

TITLE XX: Section of the Social Security Act-Social Services

VI: Visual Impairment.

WIC: Special Supplemental Nutrition Program for Women, Infants and Children-DHS Program